THE DEVELOPMENT OF AN INSTRUMENT TO SURVEY EXPERIENCES WITH AND ATTITUDES TOWARD SELF-HELP GROUPS

BY

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THE DEVELOPMENT OF AN INSTRUMENT TO SURVEY EXPERIENCES WITH AND ATTITUDES TOWARD SELF-HELP GROUPS

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The purpose of this study was to develop an instrument, The Survey of Attitudes toward and Experiences with Self-Help Groups (SAESHG), and to answer three research questions regarding the instrument's content validity, factor structure, and reliability.

Section I of the SAESHG was a survey of experiential knowledge and Section II, a survey of theoretical knowledge of self-help groups. Item development was based on extensive review of the literature on self-help groups. The items were subsequently evaluated by a panel of experts possessing both experiential and theoretical knowledge of self-help groups.

One thousand members of the American Mental Health Counselors Association (AMHCA) were surveyed, and 410

returned completed instruments. Three hundred and fifty one surveys with at least 50 of 53 items completed were used for the analyses. Item responses were factor analyzed and four factors were found. Generally supported from the analyses were the construct areas of purposes/activities, characteristics, and relationship to other helpers. Alpha coefficients for the four factors were .91, .64, .66, and .56 respectively. Additional refinement of the SAESHG was suggested and various studies recommended to further validate the instrument.

CHAPTER 1

INTRODUCTION

> Therapy is an essentially human activity which has been preempted and monopolized by a therapy elite and sold as a commodity on the open market (Glenn & Kunnes, 1973, p.8).

Self-help groups trace their origins to early man. Associations in the Mesolithic period, first formed for the purposes of hunting and gathering, evolved during the Neolithic Period into agricultural villages. These associations, based upon shared ties and common interests, reached their crest in the modern urban-industrial period. Over the past two decades, a growing consumerism has lead people to take greater responsibility for their own needs. This initiative has been associated with the proliferation of mutual help groups and organizations (Silverman, 1986). Found in all parts of the world, mutual aid associations or mutual help groups, now referred to as self-help groups, have played a continuous role in social and cultural change and in the evolution of society (Anderson, 1971).

Currently, there are over 500,000 self-help groups (Katz, 1981). These groups, with a combined membership of

15 million people, range in size from Alcoholics Anonymous (A.A.) which has 750,000 members in over 40 countries, to local neighborhood groups which may have less than ten members. The concept of mutual aid is not limited to one culture or type of political environment. Self-help groups range from organizations of welfare mothers in Australia to hypertension clubs in Yugoslavia, to relatives of mental patients in Austria, and to consciousness raising among children in England (Katz & Bender, 1976b).

Many views concerning self-help groups have been stated in the literature. Authors consider it a social movement (Katz & Bender, 1976b; Sidel & Sidel, 1976; Toch 1965; Vattano, 1972), a spiritual movement or secular religion (Hurvitz, 1974; Mowrer & Vattano, 1976; Newmark and Newmark, 1976), a support system (Killilea, 1976), a phenomenon of the service society, (Gartner & Reissman, 1974), a subculture, or an agency of social control and resocialization. Prominent among these orientations is the view that self-help groups are part of the service society, particularly in the area of mental health services (President's Commission on Mental Health, 1978). Authors L'Abate and Thaxton (1981) typed self-help groups into three categories: physical, emotional, and social. Examples in these categories include the Endometriosis Association for the physical type,

Alcoholics Anonymous for the emotional type, and Parents Without Partners for the social type.

The rise and fall of mutual aid or self-help groups is closely linked to economic and social conditions as can be seen by tracing the history of these organizations. In some form, they have continued from earliest times to the present and will, no doubt, persist as long as the imperfections of social living and social institutions endure (Katz, 1981).

Social and economic conditions have also affected the development of therapy. Therapy in the United States began in the early 19th century with physicians treating emotional problems as stemming from abnormalities in the brain and/or nervous system, or as evil "humors" circulating in the body. Some kind of curse or bad living also was considered to be a likely cause of emotional disorders. Treatment consisted mainly of containment in the familial home or imprisonment.

In the early 1800s, so-called mental patients began to be seen as human beings with something wrong with their bodies that was causing problems with their heads. This organic approach to mental illness became a new area of study. In Europe, where the asylums were overcrowded, patients were released and treated with various techniques.

Physicians, as heads of asylums, set up diagnostic systems to govern the detainment and release of the interred masses.

In the United States, the asylum system was largely for the well-to-do. Such places had large staffs and few patients. Therapy techniques included hydrotherapy, simple talks, walks, work, fear, whirlabouts in a chair, showers, and so on. The cure rate was actually fairly good. Those unable to afford the asylums turned to clergy, family, friends, quacks, and faith healers. Following the Civil War, with the influx of immigrants who could speak little English and who were culturally different, and large numbers of poor, ill-educated people pouring into the cities, the asylums became storage bins for the socially undesirable as well as the "insane." Cure rates dropped, and treatment was mainly custodial care until psychiatry emerged.

Psychiatry became a medical specialty as an off-shoot of neurology. By the turn of the 20th century, it had given birth to psychoanalysis with its theory of inner conflict and the associated psychodynamic approach. According to Glenn and Kunnes (1973), Freud and his colleagues strongly influenced American psychiatry which was at the top of the therapy hierarchy. Freud's theories and techniques, however, were based on the treatment of rather disturbed but somewhat functional white middle-class cases, not the psychotic, interred mixed masses. Freud's theories split

psychiatry into two camps, the proponents of intrapsychic conflict and the more medically minded psychology of the older physical/organic school. In either case, therapy was still firmly in the hands of the medical professions (Glenn & Kunnes, 1973).

As the 20th century progressed, people other than physicians entered the therapy profession. Soon after World War II, therapy suddenly came of age. From the viewpoint of Glenn and Kunnes (1973), psychiatrists and psychologists were hired to sell bourgeois psychology to everyone, and the government suddenly discovered the value of the idea of "mental illness." Therapy was a'comment on all', a cure-all. Social workers, clinical psychologists, hospital personnel, and others claimed their own special expertise all their own. Therapists became consultants to every sector of American life. Psychologists began to develop their own "clinical" talents, and social workers did the same. In fact, each group of ancillary personnel began to develop its own ideology, its own professional history, and its own "expertise" (Glenn & Kunnes, 1973).

After 1963, newly created mental health centers, with their expanded programs featured a proliferation of jobs for therapists. Therapy became big business. For some time, it seemed that therapists, or helping professionals, could afford to simply ignore the self-help movement. A

committee report on "Humanizing Health Care" contained a section on self-help and medical self-care outlining the nature of these activities, addressing policy implications, and suggesting needed directions for research. It was the first time that a professional organization of social scientists recognized the importance of self-help organizations both as a form of social institution and as a useful field of study (Humanizing health care, 1977).

Since the early 1970s, when helping professionals began to recognize and write about the self-help movement, several changes have occurred in the relationship between the helping professional and self-help groups. Professionals' reactions, which initially ranged from hostile to ambivalent, now seem to be more accepting, with a trend toward "symbiotic cohabitation" (Riordan & Beggs, 1987). A survey of helping professionals attitudes toward and experiences with self-help groups would provide information to substantiate or refute this suggestion of symbiotic cohabitation. The survey could also provide information as to the autonomy of the self-help movement from the professional sector. This could be gauged by assessing professionals relative involvement with self-help groups. Finally, results of the study might provide information as to the degree of acceptance by helping professionals of self-help groups as an alternative treatment method.

If the fate of the paraprofessional movement in the human services was any indication, the attitudes of the professional community will have a great deal of influence on the self-help movement. The role of the paraprofessional was developed in the 1960s to capitalize on "natural helpers" or those people in the community who seemed to be able to very effectively establish helping relationships with their neighbors. They were hired by various agencies to do their helping under the auspices of the agency (Pearl & Riessman, 1965). Gradually, they came to be supervised by agency workers, and their work was regularized by agency rules and professional practice. Formally or informally, they were pressured to improve their education and become more professional. Their unique helping qualities became less and less valued by the agencies and by themselves. They have long since been absorbed into agencies, adopting the values and working within the organizational constraints of those agencies (Silverman, 1986). This tendency to coopt may be affected by the positive or negative attitudes and experiences that professionals have toward self-help groups. The type of attitudes that professionals have toward self-help groups will play a decisive role in the nature and extent of collaboration that professionals will have with self-help groups.

Statement of the Problem

As self-help groups have grown in the last 25 years, discontent with professional services viewed as ineffective, unaffordable, and irrelevant also has increased. Self-help groups could be seen as an alternative or adjunct to professional services. Caplan and Killilea (1976), Dumont (1974), Gartner and Reismann (1974), and Levy (1976) noted that self-help groups are increasingly recognized as important resources in meeting the mental health needs of our society. Self-help groups are recognized as resources both by people who, in large numbers, are turning to various self-help groups for support, and by helping professionals who are considering ways of utilizing self-help groups in the mental health system. Interest in self-help groups also has extended to other individuals and/or professionals concerned with incorporating such groups into their service delivery system.

Some guidelines for the utilization and/or collaboration of self-help groups were in a report of The 1978 President's Commission on Mental Health, which included several recommendations for initiatives by the federal government in community mental health. Among the initiatives particular to self-help groups were to improve the linkages between natural networks and professionals, to recognize and strengthen natural helping networks, and to

monitor changes in American life (President's Commission on Mental Health, 1978). Specific objectives suggested were to provide directories of self-help groups to mental health centers for dissemination to the general public; develop a clearinghouse for dissemination of information on mutual help groups; sponsor conferences to "enable professionals and members of self-help groups to learn from each other; and develop curricula in all helping related undergraduate and graduate programs on the nature and function of community support systems, natural helping networks, and mutual help groups" (President's Commission on Mental Health, 1978, p.12).

The relationship between self-help groups and helping professionals is an important one which should be studied. Self-help groups not only affect the growing number of people who join them, but they also affect a widening circle of people within the community. As self-help groups become more action-oriented, they will need to broaden their support base in order to achieve their goals. It is important to understand the attitudes of people in the community, including mental health professionals, toward self-help groups to evaluate such things as the probability of the self-help group being able to achieve its goals within the community.

To date, few studies have been conducted surveying the attitudes of various helping professionals toward self-help groups. Unfortunately, they all followed an ad hoc design in that all instruments were developed for a specific study. Each had serious methodological limitations and nothing was provided on validity or reliablity of the instrument used.

Need for the Study

Thus far, the self-help movement has been ignored by most social scientists. Some attempts have been made to study the effectiveness of self-help groups. The paucity of adequate outcome studies stems from the lack of attention and problematic issues relating to the technical complexity of the research (Lieberman & Borman, 1976). The research task can be defined as "(1) what kind of changes are produced by (2) what kinds of group methods applied to (3) what kinds of group members by (4) what kinds of group leaders under (5) what kinds of group environment conditions" (McGovern, 1983, p.468). According to Priddy (1987), the problems encountered while doing outcome research on self-help groups are due to two factors: the complexity of group phenomenon and the primitive state of theoretical development in the area of group treatment. He

concluded that it may be an impossible task to determine the effectiveness of self-help groups using empirical methods.

At this point, there is really no aspect of the self-help movement which has been adequately researched. Few instruments have been developed to measure the outcomes of participation in self-help groups, the effectiveness of groups in dealing with specific problems, or the attitudes of members of self-help groups toward helping professionals. Of the few, even less have been 11 validated. The need exists for their development, however.

Killilea (1976), in a review of the literature on self-help groups, suggested that

> What is needed are more studies looking at the actual relationship in nature between individual professions and individual mutual help groups; referral patterns and kinds of transactions between mutual aid organizations, individual professionals, and formal human service institutions. (p.82)

One important area for research is how self-help groups are viewed by others (Levy, 1978) because self-help groups are having an increasingly active role in their communities. This increased activity may be due to the fact that self-help groups are being recognized as a means of achieving some of the goals of community mental health centers. The degree of support a self-help group receives from professionals within the community, the nature of its institutional affiliation, and the character of its community, all will affect the manner in which the group

functions and how effectively. As community institutions and agencies become increasingly involved in sponsoring self-help groups, their attitudes will affect the growth and effectiveness of these groups (Levy, 1984).

Self-help groups are viewed by Lurie and Shulman (1983) as therapeutic and physical extenders of services. They feel self-help groups and professionals providers can be major allies in identifying needed services and marshalling consumers' active participation to work within the health care system to develop needed services.

According to Chutis (1983), the provision of services to self-help/mutual aid groups is a natural outgrowth of the goals, objectives and activities of the consultation and education (C&E) departments of community mental health centers. Recently, C&E services have expanded to include the education and training of natural community care-givers, such as self-help groups, in an effort to better serve the mental health needs of the larger community (Snow & Swift, 1981). Results of a survey of 244 mental health centers throughout the country conducted by Hermalin and Swift (1981) indicate that the importance of involvement with self-help groups has been widely recognized. Staff in surveyed facilities reported initiating self-help groups, providing space, and making referrals as some methods of collaboration. There is a need to gather information on the

attitudes of self-help members, community members, and helping professionals, among others, toward self-help groups.

The focus of this study was to develop an instrument to examine helping professionals' attitudes toward self-help groups. There is a lack of adequate assessment tools to gather this needed information. These two factors, a need for information, and a need for a tool to gather the information, were addressed in this study by the development of an instrument to assess attitudes toward and experiences with self-help groups.

Purpose of the Study

The purpose of this study was to develop and validate an instrument to assess helping professionals' experiences with and attitudes toward self-help groups. Content and construct validitation procedures were used. The internal consistency of the instrument also was determined to provide some evidence as to the reliability of the instrument.

Significance of the Study

The development of an instrument to measure attitudes toward self-help groups would assist the researcher

examining perceptions of self-help groups. The instrument provides a method of assessing the current attitudes of helping professionals toward self-help groups as well as providing the means to assess helping professionals' attitudes in the future. The instrument facilitates information gathering. It has potential uses for future research efforts. An instrument assessing the attitudes towards self-help groups also allows comparisons of different populations, after validation on those populations. The instrument can be used to develop profiles of those persons, or groups of persons, most favorable and least favorable toward self-help groups. The instrument can be a standard assessment tool which can promote generalizations across studies.

The instrument can be used to assist professionals in their consultation activities with other professionals or with self-help groups. The assessment of the consultees' attitudes can be an excellent method for professionals to begin the consultation process. The instrument also can be used with self-help groups to assist them in their consultations with professionals or in their assessment of the degree of openness of systems or organizations to their groups. Additionally, the instrument may aid professionals in determining whether to refer clients to self-help groups

by using it to assess the attitudes of those clients for whom the professional is considering referral.

In the area of training, the instrument can be used as a preliminary assessment tool to aid in planning training activities for helping professionals. By assessing the attitudes of the trainees toward self-help groups, trainers can prepare a program to either strengthen or challenge these attitudes. Much discussion also can be generated concerning training needs. The instrument can be used to identify those professionals who have both experiential and professional knowledge of self-help groups. These individuals can be important role models in training programs for collaborating with self-groups (Borman, 1976). The instrument can be used by students in professional training programs as a self-assessment tool. By assessing the attitudes of its students, a departmental faculty can better plan further training or practicum experiences with self-help groups or determine whether such steps are necessary.

As previously discussed, the instrument was developed for multiple uses. At the same time, it was beyond the scope of this study to validate the instrument on all populations for which it might be used. For the purpose of this study, members of the American Mental Health Counselors Association (AMHCA), a diverse group of helping

professionals, were selected as the group of professionals to use for validation purposes.

Definition of Terms

The terms listed below are defined in the following manner for the purposes of this study:

Attitude is a predisposition toward a psychological object, i.e., person, thing, concept, or idea.

Human service professionals are helping professionals in the areas of mental health, psychology, behavioral science, and medicine.

Mutual aid/mutual assistance is cooperation among groups or individuals for the purpose of support or assistance.

Mutual aid groups are voluntary groups whose purpose is to provide help and support for its members in dealing with their problems and improving their psychological functioning and effectiveness.

A Natural helping network is a group or system of people voluntarily created and continued by themselves for the purposes of support and mutual aid.

A Self-help group is a voluntary group whose purpose is to provide help and support for its members in dealing with their problems and improving their psychological or physical

functioning and effectiveness. The group's origin and sanction for existence rest with members of the groups themselves, rather than with some external agency or authority. The group relies on its members' efforts, skills, knowledge, and concern as the primary source of help. The group is generally composed of members who share a common core of life experiences and problems. Its structure and mode of operation are under the control of members, although they may, in turn, draw upon professional guidance and various theoretical and philosophical frameworks (Levy, 1978).

Support systems are continuing interactions with another individual, a network, a group, or an organization that provide individuals with feedback about themselves and 17 validation of their expectations about others (Caplan, 1976).

Therapists are helping professionals in the areas of mental health, psychology, and behavioral science.

Voluntary associations are groups of individuals who share a common need or problem and who seek to use the group as a means of dealing with that need or problem. This term can be used synonymously with self-help groups and mutual aid groups.

Organization of the Study

The remainder of this study is organized into four chapters. A review of related literature on self-help groups and professional collaboration with self-help groups is presented in Chapter Two. The research questions, theoretical basis of the instrument, item development, pilot study, field test of the instrument, and limitations of the study are described in Chapter Three. The results of the study and a discussion of these results are presented in Chapter Four. Conclusions, implications, a summary, and recommendations for future studies are discussed in Chapter Five.

CHAPTER 2

REVIEW OF RELATED LITERATURE

> Who then can so softly bind up the wound of another as he who has felt the same wound himself? (Thomas Jefferson)

The review of related literature includes an overview of the self-help movement, the relationship of self-help groups and society, the power struggle between self-help and professionals, various methods of collaboration between self-help groups and professionals, research on self-help groups, and a summary.

Self-Help Movement

Self-help or mutual aid groups, broadly defined as voluntary associations among individuals who share a common need or problem and who seek to use the group as a means of dealing with that need or problem (Durman, 1976), have early historical origins. Mutual aid groups began in the Mesolithic Period when individuals banded together to hunt and gather food. By the Neolithic Period, agricultural villages, formed on the basis of kinship ties and territorial groupings, were widespread (Anderson, 1971).

Prince Peter Kroptkin, in a series of articles refuting Darwinism written in the 1890's, argued that mutual aid played a role in the development of all animal species, including man. He maintained that man could survive the evolutionary process only through mutual aid and social cooperation. These two factors, mutual aid and social cooperation, were key elements in the formation and continuity of the family, tribe, village, and state (Kroptkin, 1914).

Sociologist Louis Wirth (1938) agreed with Kroptkin that mutual aid groups developed very early in civilization and were found in most societies of the world. Wirth found no single cause for the development of self-help groups. He concluded that voluntary associations rise when primary bonds of kinship, neighborhood, family, and religion are weakened as well as thrive when the primary support system is supported (Smith & Freedman, 1972).

By the Middle Ages, mutual aid groups, originally a means of insuring physical survival, had expanded into the work arena. Much of the mutual aid in the Middle Ages and Renaissance was exclusive in character, however, limited to members of the guild or community. Strangers, pilgrims, or other non-members of the groups had to rely on the meager resources of the church or town charity for assistance.

With the development of the Industrial Revolution in England and its ensuing social effects came "Friendly Societies." From early prototypes of the guild system, Friendly Societies were developed by the common people of England to cope with the stresses of industrialization. Before 1800, 191 such societies were founded. Generally, they were organized around occupations, providing members with funds for illness and old age. Friendly Societies aroused greatest opposition from employers who viewed the groups as schools for politics and class warfare (Katz & Bender, 1976a).

The growth of capitalist enterprise during the latter part of the 18th Century increased the hardships of the working class. Friendly Societies became used more and more as trade unions to defend or better the members' working conditions (Cole & Wilson, 1951). Thompson (1963) estimated the total memberships of these societies as 648,000 in 1793, 704,000 in 1803, and 925,000 in 1815. In addition, many groups failed to register with the authorities due to the latter's hostility towards them. Foster (1974) wrote, "the Friendly Society was one social institution that touches the adult lives of the near majority of the working population" (p.216). Even in modern times, Friendly Societies are still evident. Beveridge (1948) found 18,000 Friendly Societies

functioning in 1945 to provide housing and building services, workingmen's compensation and cooperative stores.

Another outgrowth of the Industrial Revolution, in addition to Friendly Societies, was formalized consumer cooperatives. These developed rapidly in England and spread to other parts of Europe and later to North America. There was a clear mutual aid component in these cooperatives but few survived because the base of group cohesion was a "cash nexus"-- a poor foundation upon which to build continuity of sentiment and human caring (Katz & Bender, 1976a).

The historical development of mutual aid groups in the U.S. closely paralleled that of the Mother Country. When colonists first came to America, it was necessary to band together for protection against nature, to assist each other to insure survival. Once a community was established, communal efforts were discarded in favor of the American tradition of rugged individualism. The wealth of virgin territory, seemingly unlimited natural resources, and the lack of state controls, made this move to individualism possible. As the American ethic of self-sufficiency developed, the needy were viewed as social outcasts-- unfortunate due to their own moral failures. Any charity was provided through private agencies or individuals. This

situation was to remain unchanged until the Great Depression.

With the growing complexity of town and rural problems, new self-help forms emerged to meet common difficulties. For example, groups of dairymen formed mutual aid associations in 1800 to insure markets for their products, and the Mormons founded irrigation cooperatives to bring water in to Utah (Katz & Bender, 1976a). The advent of the Industrial Revolution in the United States in the mid-nineteenth century, brought the same problems for the working class that had first become manifest in England-grievously long working hours, paltry pay, hazardous working conditions, forced child labor and chronic illnesses. These forces united the oppressed workers. Self-help, as a means of survival, re-emerged in the labor movement.

In the 1870s a league of consumer cooperatives called the Sovereigns of Industry was organized. This movement was taken over by the Knights of Labor, an all-inclusive national trade union body which attained a membership of 703,000 in 1886 (Katz & Bender, 1976a). Their slogan, "An injury to one is the concern of all" (Boyer & Morais, 1975, p.89) served to unite workers from hundreds of trades around demands for an eight hour working day, a minimum wage, grievance proceedings, safer working conditions, and an end

to child labor. The idea of strength in unity has been the foundation for self-help groups ever since.

A large part of the work force was composed of immigrants at this time. As newcomers in a strange land, the immigrants were at the bottom of the heap, forced to take the lowest paying jobs and live in the poorest housing. Beginning around 1800, large networks for self-help and mutual aid were developed by a variety of these immigrant groups. The Greek community in Massachusetts had over 1,000 members in its Pan-Hellenic Union in 1912. The Italians, Lithuanians, Germans, Russian and Polish Jews all set up similar organization to provide services ranging from free burials to free loans societies and wayfarers lodges. As the needs of the immigrants lessened, and their assimilation increased, these organizations slowly declined.

Self-help groups were declining when the Great Depression overwhelmed the nation. With one third of the population ill-housed, ill-fed, and ill-clothed, the government was forced to set up programs. The service concept was born. Social Security, Vocational Rehabilitation, and Maternal and Infant Care were some of the varied programs created to give service to people with specific needs.

Coupled with the Great Depression, the repeal of prohibition in 1933 increased the numbers of alcoholics who,

in turn, added to the growing numbers needing inexpensive but effective psychological services (Brenner, 1973). The existing systems were unable to meet the increased demand for help. New solutions were necessarily created. Many social experiments, including the development of self-help programs for social amelioration, were undertaken to solve the problems of the Great Depression. Seeking new and cheap methods to deal with multitudinous problems, the government created several self-help programs--Tennessee Valley Authority, Civilian Conservation Corps, Works Progress Administration and National Youth Administration. At the same time, the people turned to grassroots activities--wildcat strikes, resistance to evictions and foreclosures, and communal soup kitchens (Hurvitz, 1976).

Inclusive in the service concept was the belief that the professional knows best and that the professional has the power in the relationship. The client, if unhappy with this arrangement or critical of the service, was labeled uncooperative or resistant (Katz, 1970b). The third surge of self-help groups which occurred following World War II was initiated by two groups in response to being labeled or neglected by professional and bureaucracies (Steinman & Traunstein, 1976). One group, parents of the mentally retarded, overcame almost insuperable odds to create schools and workshops for their children (Steinman & Traunstein,

1976). The other group, alcoholics, whom professionals had been notably ineffective in treating, created their own treatment. Their organization, Alcoholics Anonymous (A.A.) has become the model for numerous self-help groups which followed. These include Gamblers Anonymous, Neurotics Anonymous, and Overeaters Anonymous.

Competing Explanations of Self-Help Group Development

Four viewpoints explain the development of self-help groups (Lieberman & Borman, 1976). One view is that self-help groups developed from unmet needs. An example to illustrate this viewpoint is the growth in Alcoholics Anonymous which was the result of inadequate responses by professionals to alcoholism. A second view is that self-help groups developed as an alternative to services already provided. This viewpoint has been used by Tracy and Gussow (1976) to explain their finding that self-help health related groups are increasing at the same time as professional services are increasing. They suggest self-help groups offer support, technical assistance, models of dealing with an illness, social activity and usefulness, and help with an adaptive problem which professionals are not providing.

A third proposed view is that self-help groups develop from the widespread feelings of alienation in our society

(Mowrer & Vattano, 1976). Striving to meet their needs for affiliation and a sense of community, individuals turn to a group. Meeting these needs through the group becomes even more important than the aim of the groups. A fourth view, that self-help groups develop from other affiliative arrangements outside kith and kin (Tax, 1976), explains development to provide a basis for intimacy, identity, and affiliation.

Back and Taylor (1976) have suggested an additional viewpoint to the four offered above. They viewed self-help as representing a social movement. They applied Blumer's five stages of a social movement to self-help groups. These stages: agitation, group forms which tries to cure the unrest, development of morals, development of ideology, and final achievement of goal (Blumer, 1969), are paralleled in the reports of some self-help groups. Katz and Bender (1976b) concurred that self-help groups can be viewed as a social movement. They reasoned that self-help is change directed and seeks alterations in (1) its constituency's relation to society per se, (2) dominant institutions of the society, and often in (3) the personality and behavior of the member him/herself.

From a review of the literature on self-help, Killilea (1976) concluded that mutual help organizations are not a simple phenomena or a single movement. She divided the

literature into 20 categories of interpretation. These include the categories of support systems, product of social and political forces, phenomenon of service society, alternative care giving systems, adjunct to the professions, subculture-way of life, supplementary community, agencies of social control and resocialization process, and therapeutic method.

Even this multiplicity of interpretations may not prove adequate for each of the over 500,000 self-help groups with their 15 million members (Evans, 1979). The sweep of the concept of mutual aid itself offers wide latitude for expression in its social forms. It is not limited to one culture or type of political environment but includes such diversity as organizations of welfare mothers in Australia, hypertension clubs in Yugoslavia, relatives of mental patients in Austria, consciousness raising among children in England (First International Conference on Self-Help and Mutual Aid in Contemporary Society, 1976).

From reviewing the historical development of self-help and acknowledging the influence of social and economic factors upon that development, it becomes clear that, changes in the forms of help are shaped at least as much by the predominant social forces of the times as they are by thoroughly supported developments in the science of human behavior (Levine & Levine, 1970).

Today, as in the past, social conditions and economic factors are prime elements contributing to the growth of self-help groups. Some of the social conditions which have shaped the need for self-help groups include industrialization with its accompanying growth of vast business and governmental structures, high cost of professional services, loss of options in life choices, decline of faith in established institutions, feelings of powerlessness and inability to control events, decline in a sense of community and identity, and erosion of the family structure (Katz & Bender, 1976b).

Sidel and Sidel (1976) referred to self-help groups as the "grass-roots" answers to such social forces as the rate and pervasiveness of technology, the complexity and size of impersonal institutions, and professionalization of services that were previously provided by non-professional individuals. Durman (1976) viewed the self-help movement as a mandate for refocusing planning efforts of the next decade from the agency to the helping network; from services which ignored existing natural resources to efforts which encourage and foster the ability of ordinary people, working together, to resolve many of life's difficulties without professional intervention.

Katz (1970a) encouraged self-help groups to continue in their militancy, renewal, and shake-up every few years to

renew their vitality. Katz believes self-help groups can be innovative and challenging, that they can monitor professional services to ensure more and better provision of services, and fight the dead hand of bureaucracy. In agreement with Katz years prior, MacIver (1931) felt mutual aid associations have a flexibility, an initiative, a capacity for experiment, a liberation from the heavier responsibility of taking risks, which the state rarely, if ever, possesses. Associations can foster the nascent interests of the groups and encourage social and economic enterprise at the growing points of a society.

It is this freedom to experiment, this struggle with society which Sidel and Sidel (1976) addressed. They warned that self-help groups should not be used to foster adjustment to an unjust society but should struggle to modify that society. They saw that self-help could be used to divert attention from the maldistribution of resources and power, that it could fragment communities and families from each other, that it could foster the ideology of blaming the victim, and that it could advance "medicalization" of all health-related problems. For prevention of these dangers, they suggested that the self-help movement be placed in the context of an appropriate set of broader social goals within an ideological framework (Sidel & Sidel, 1976). Finally, they encouraged self-help groups to be as

concerned with teaching professionals how to work humanely with clients as with helping the people directly to help themselves.

Others who have recognized self-help groups as an important resource in meeting the mental health needs of society include Caplan and Killilea (1976), Dumont (1974), Gartner and Reissman (1976), Levy (1976), and Van Til (1978). Van Til felt self-help groups appear to be a very effective but quite inexpensive way of meeting human needs. He believed that groups offer potential to society and individual organizations to greatly expand the number of people served. Levy (1976) viewed self-help groups as political and sociological phenomenon and a psychological phenomenon. Levy considered self-help groups as challenges to established institutions, as attempts to redistribute power, and as responses to certain failures in the social order.

The Power Struggle Between Self-Help and Professionals

Self-help can be viewed as an attempt to redistribute power (Levy, 1976), to place more power in the hands of the client by taking away power from the professional. To better understand the nature of this conflict, some background information on the source of power of both self-help

groups and professionals will be examined. A comparison/ contrast between the two also will be drawn.

Robert Morris (1973) listed functions performed by publicly provided services in response to client needs. These functions (and some of the services which fulfill them) include: a) assessment and counseling (group therapy, family planning); b) environmental arrangements (half-way houses, nursing homes, homemaker services; c) training, education, and equipment (work training, nutrition, home management); d) protective and legal (protective services for adults and children, legal aid); e) liaison (information and referral, resource mobilization--social change); and f) transportation (escort service).

Two needs not met through public service, but prominent in the literature on self-help, are support and advocacy (Morris, 1973). Because self-help groups provide extended contact over a long period of time at all hours, they are better able to give support than conventional services. Because self-help groups are often founded due to the delivery system being unable to meet their needs, self-help groups are often advocates for change.

Frank Reissman (1976) concluded that the power of self-help comes from five basic components. First is the helper-therapy principle. This states that the person giving the help often receives more benefit in the process than the

person they are trying to help. The second component is consumer intensity. The group is geared towards meeting the needs of the consumers (group members). The third component is the professional dimension with its emphasis on practicality and common sense. Suggestions made in the group have been tried by group members. The fourth component is that caring and spontaneity are central. Fifth is the demand that the individual can do something for himself. The five components are what make mutual aid groups empowering and thus, dealienating (Reissman, 1976).

The normative characteristic of a profession is autonomy--the right to determine work activity on the basis of professional judgement. Autonomy, in turn, is based on two other characteristics of a profession: a store of esoteric knowledge and a service orientation or altruism (Haug & Sussman, 1969). Professional knowledge is based on knowledge developed, applied, and transmitted by an established specialized occupation. This knowledge is viewed by the professional as the private property of the provider and gives him/her the power to dominate the less privileged, propertyless client (Marieskind & Ehrenreich, 1975).

Self-help, in contrast, is based upon experiential knowledge or truth learned from personal experience. The wisdom that results from personal experience is concrete,

specific, and common-sensible (Borkman, 1976). The two types of knowledge are not mutually exclusive but professional knowledge is better known and a more widely accepted source of truth in the United States than experiential knowledge (Borkman, 1976). The greater acceptance and higher value of professional knowledge has led to an imbalance of power between the professional and the client.

According to Haug and Sussman (1969), clients are in revolt against delivery systems for knowledge application which has been controlled by the professional. Clients are against the encroachment of professional authority into areas unrelated to professional claimed expertise.

In addition to challenging knowledge application, the other challenge is to the professional's service orientation. Governmental response to the Great Depression of the 30's marked the initiation of the service concept. Social Security, Vocational Rehabilitation, and Mental Health programs were created to give service to people with specific needs. A basic tenet of the service concept was that the professionals knew best, that they had the power of deciding what was right for clients, and that clients were resistive or uncooperative if they did not like the services provided (Katz, 1970a). The service concept set up between the professional and the client an unbalanced power relationship.

Haug and Sussman (1969) believed that the power of the professional depends upon the consent of the client. As clients have struggled to shift the balance of power, professionals have sought to preserve both their power and autonomy by stifling challenges. Hospitals form patient councils, poverty programs have "indigenous" community representatives, and students are placed on advisory boards. In this way, professionals give up only a little power and socialize the descendants, according to Haug and Sussman (1969). The professional self-image as a person of knowledge, compassion and of power is left, more or less, intact. Without the solution of cooperation, the struggle could result in less diffuse power, a narrowing of autonomy, and deprofessionalization of the professional.

As a means of summarizing the nature of the power struggle between self-help groups and professionals, a contrast of the two is presented. Self-help groups use group parity, are free, and held in nontherapy-oriented milieu. Professionals use authoritative therapy, charge fees and work in therapy-oriented milieu (Hurvitz, 1974). Self-help groups encourage family involvement, members are similar and identify with each other, act as role models and set examples. Members are active, judgemental, and critical. They divulge to each other and must give as well as receive support (Reissman, 1976). Professionals do not

confront the family, do not identify with the patient, are not role models, do not set personal examples, are nonjudgemental and noncritical. They listen as the patient unilaterally divulges and those disclosures are secret. Patients expect only to receive support from the professional who does not expect it back in return, other than financial (Hurvitz, 1974).

A self-help group has been described in the following way by Reissman (1976). In a self-help group, members are not concerned with symptom substitution. They reject disruptive behavior and hold each other responsible. Peers aim to reach each other at "gut level." An emphasis is placed on faith, will power and self control.

The professional, as contrasted by Hurvitz (1974), is concerned about symptom substitution if underlying causes aren't removed. The psychotherapist accepts disruptive behavior, absolves the patient by blaming the cause. He/she doesn't aim to reach "gut level," emphasis is on etiology and insight.

With self-help groups, the members' intersocial involvement has considerable community impact. Primary emphasis is on day-to-day victories: another day without liquor or drugs, etc. The group provides continuing support and socialization. With orthodox psychotherapy, the therapist-patient relationship has little direct community

impact. Everyday problems are subordinated to the long-range cure. Extracurricular contact and socialization with the therapist is discouraged (Hurvitz, 1976).

Orthodox psychotherapy has a lower cumulative drop-out percentage than does self-help groups. In orthodox psychotherapy, the patient cannot achieve parity with the psychotherapist. By contrast, members of self-help groups may themselves become active therapists (Hurvitz, 1974; Reissman, 1976).

It would appear from the writings of Reissman (1976), Powell (1975), Katz and Bender (1976b) that there are real contrasts between self-help groups and professional services. Dewar (1976) has been one of the few challengers to this assessment. Dewar believed that self-help, in the health area, does not offer an alternative to professional services. He believed the services are similar, the difference is in who offers the services. Dewar felt that patients are socialized into thinking in the professional mode and that the groups apply professional solutions which are only as effective as the professionals they mimic. In their study of self-help groups in health-related areas, however, Henley (1976, p. 86), quoted the chief of cardiac surgery as saying, "the most important thing I have learned is that rehabilitation takes place in the peer group, with medical personnel in an advisory role."

A discussion of the merits of self-help versus professional therapy could be supported by expert opinions from both sides. The self-help movement is neither deterred by lack of research nor lack of participation by professionals. As Dumont (1974, p. 633) stated, "the redistribution of political and economic power is meaningless if the power residing in professionals is not redistributed." One method of power redistribution which might prove beneficial to both the self-help movement and professionals is collaboration.

Professional Collaboration with Self-Help Groups

> ...Forging the links between professional and non-professional helpers is hard work; there are barriers of language, education and expectations. (Fields, 1980, p. 2)

The power struggle between self-help groups and professionals can be resolved in several ways. One way is for self-help groups and professionals to strengthen their autonomy and allow little cross-over of clients or resources. Another possibility is for professionals to recognize the unique qualities of self-help groups and seek to collaborate with them in ways which still preserve that uniqueness. Still another possibility is for helping professionals to be as actively involved as they are allowed to be in whatever manner they are allowed with self-help

groups. Each of these possibilities has been tried and each has had varying outcomes.

Although it would appear at first glance that self-help groups are autonomous, a review of self-help groups reveals that many of them were begun by professionals. Groups in which professionals played a leading role include: Recovery, Inc., begun in 1937, by Dr. Abraham Low, a psychiatrist who wanted a continuing support group for his mental health clients; Integrity Groups, begun in 1945 by psychologist O.H. Mowrer; G.R.O.W., begun in 1957 by clergyman Father Keogh; Compassionate Friends, begun in 1969 by Reverend Stephens for parents dealing with the death of their child; Parents Anonymous, begun in 1971 by social worker Leonard Lieber; and Epilepsy Self-Help, begun in 1975 by social psychologist Lawrence Schlesinger (Lieberman, Borman, & Associates, 1979). Recovery, Inc., which has continued to grow after the death of Dr. Low, is now the largest ex-mental patient group with over 15,000 members in 1,000 groups (Gartner & Reissman, 1980).

Characteristics of these men or others like them who found or support self-help groups include willingness to look beyond conventional theories, acceptance of a broader definition of afflictions, interest in expanding their skills and techniques, focus on rehabilitation and after-care, concern for neglected populations, willingness to

alter their professional role to include collaboration and support, willingness to form a group in a variety of settings, and willingness to minimize their fees (Lieberman, Borman, & Associates, 1979).

Aside from the findings that professionals have been involved in the founding and support of many self-help groups, it has also been found that most participants utilize professional help to a greater extent than do non-members of self-help groups (Lieberman, Borman, & Associates, 1979). In view of these findings, it is somewhat ironic that the professional sector has neither been trained to consider mutual help groups as a referral option nor is under any pressure from peers or clients to do so. Under these circumstances, professionals remain oblivious to existing mutual help groups or come to perceive them as irrelevant to professional practice according to Gottlieb (1980). If this professional attitude does not change, if professionals do not find some common ground with the self-help movement, Dumont (1976) has predicted that professionals will become increasingly cloistered, self-serving, and irrelevant.

As discussed earlier, one of the ways in which professionals have been involved with the self-help movement is through organizing a variety of self-help groups. In some instances, after the groups were founded, the profes-

sional took a gradually decreasing leadership role. In other cases, professionals have always served only as advisors. Such is the case with the largest self-help organization, Alcoholic Anonymous (A.A.). A.A. encourages its members to cooperate with the professional community (A.A. Newsletter, 1980).

One result of this cooperation has been referrals from the professional community to A.A. One member in five has credited a physician or hospital with directing them to A.A. (Alcoholics Anonymous World Services, Inc., 1972). More than 1,400 treatment centers have A.A. groups. This peaceful co-existence may in part be due to A.A.'s suggestions to its members to abide by all agency rules, keep commitments, do not argue or criticize, and to represent A.A. well when working with professionals (A.A. World Services, Inc., 1979).

For professionals considering referring a client to a self-help group, Powell (1975) suggested that they learn about the group before making the referral; check that the clients referred are similar to the group members so that they do not feel conspicuous; discuss the similarities and differences of the group and group activities; and check that the group is accessible to their clients. Powell also suggests that professionals be supportive of the group and plan with the clients how to use the group.

Just as professionals refer clients to self-help groups, Tyler (1976) believed that self-help groups can link clients to the professionals. This link results from group members learning from one another how to utilize effectively professional services. Self-help groups and professionals can use each other as consultants. Powell (1979) suggests that professionals think of self-help groups as a set of potential consultants who cost little and have expertise available in area such as alcoholism, child abuse, gambling, homosexuality, and divorce.

Self-help groups have used professionals as consultants for such things as improving the effectiveness of the group and its organizational structure, planning programs, participating in board meetings, and writing statements of support for grants (Gartner & Reissman, 1980). Powell (1975) suggested that professionals can use the self-help groups as a source of information, as an alternative to therapy for the reluctant client, and in collaboration with treatment by requiring participation in the group as part of therapy.

Gartner and Reissman (1980) presented the following ways a professional can collaborate with a self-help group: a) make referrals, b) help develop a group, c) consult with a group, d) offer suggestions or information to the group, e) staff the group, f) conduct basic research, g) plan programs for the group, and h) evaluate the group.

Another means of collaboration aside from starting self-help groups or consulting, is for professionals to identify and connect people in similar stressful circumstances. Through connecting these people, they have the option of beginning a group or of building a support system (Gottlieb, 1980). Use of stressful life events, social indicators, and critical life transitions can aid the professional in identifying people and getting them to develop ideas through resources of collectivity.

Strengthening support systems can serve as preventive services (Gordon, 1978). Connecting resources is one way of educating the community. By encouraging the development of networks, professionals are increasing the number of clients served. Rather than trying to reach all the clients themselves, professionals can concentrate on helping the helpers by assisting self-help members in clarifying their ideas and increasing their confidence (Patterson, 1980).

Collaboration can be seen as a mutual learning experience for the professional and the self-help group. Through consulting, leading, or researching a self-help group, professionals may increase their understanding of groups members. Such was the case with Feinburg (1970) who started a self-help group for women who had mastectomies. For self-help groups, they could develop close ties with professionals and conventional services during collaboration

(Durman, 1976). Some models have already been established for collaboration. In assertiveness training, for example, professionals train lay people who become trainers returning to the professionals for additional training from time to time. With this model, a small number of professionals have an effect which radiates out to many (Gartner & Reissman, 1977).

The assertiveness training model is very similar to the peer group rap session models in which professionals train a large number of kids then take a back-up role in the ensuing meetings. Various health groups have also been established in this manner by professionals. In reference to medical problems, professionals can diagnose the illness, prescribe relevant drugs, then help patients with similar needs find each other and come together. A final model is the professional who writes a self-help book which stimulates readers to form a self-help group on the basis of the book. Books such as Parent Effectiveness Training and Transcendental Meditation are two examples (Gartner & Reissman, 1977).

While it appears there is a variety of ways for professionals to collaborate with self-help groups, Borkman (1976) stated the collaboration is dependent on the types of professionals and their ideology and on the type of the self-help groups and its ideology. The more the profession-

al model includes experiential knowledge (truth based on personal experience), the better professionals can work with self-help groups.

It would be difficult to argue convincingly that there are no ways in which a self-help group and a helping professional can collaborate. Some caution or care must be taken, however, in order to insure a successful collaboration. In a study of a volunteer self-help group within a service agency, Kleinman, Mantell, and Alexander (1976) warned against hasty attempts to use self-help principles in an alien agency environment. They conclude that a self-help group could not be supervised by an agency because of the conflicts of the formal agency organization with the group's informality, the power differential and the disputes over values and objectives.

Van Til (1978) believed self-help can be successfully incorporated into a formal organization if both professionals and self-help clients actively consent to its development. One necessity is that the formal organization or institution be willing to bend enough to implement self-help principles.

Other authors are concerned that if professionals become involved with self-help groups, they may tamper with the ideology of such groups (Antze, 1976), they may make the group feel it can not help itself or that it needs a profes-

sional (Jertson, 1975), or that the professional will take over the group or change its orientation (Henley, 1975). Along those lines, Katz (1965) saw a pattern of professionals doing something for the recipient rather than the recipient joining in the doing. Professionals are not accustomed to cooperative ventures and they lack confidence in the individual or group to do anything for themselves. Katz (1965) suggests a need for a firmer partnership between the giver and recipient of services. He views professionals as necessary resources and as specialists rather than the only prime movers for the group.

Caplan (1974) saw the role of the professional as a "support for the supporters" and to provide continuity in group sessions. Vattano (1972) also saw the professional as a catalyst and a facilitator particularly in the early stages of the group. Mowrer (1970) suggested that universities can train and supply persons competent to start self-help groups. Regardless of which manner professionals may choose to collaborate with self-help groups, the degree of collaboration will depend in large measure on the willingness of both parties to attempt to work together. An instrument to measure the attitudes toward self-help groups could aid both parties in assessing this willingness.

Self-Help and Research

After an extensive review of the literature on self-help groups, Killilea (1976) concluded that more systematic attention, both conceptually and methodologically, should be focused on self-help groups. Caplan (1974) predicted that the self-help movement would become a major focus of systematic research during the next decade. He felt systems organized by non-professionals should be carefully studied in order to learn how to stimulate and foster supports in the population without distorting or forcing them into professional patterns. While his prediction that the movement would be a major focus of systematic research has not yet come to pass, recent studies are indicating that more professionals are becoming involved with self-help groups. How or if these groups are in turn being distorted by this involvement is an area which desperately needs to be researched, as does many aspects of the self-help movement.

Lieberman and Borman (1976) stated that the paucity of research on self-help groups is due to the following reasons: a) most social scientists ignore the movement and b) the technology to assess self-help groups is inadequate. Perhaps because the technology is inadequate, social scientists are continuing to conduct little research in the area. They do seem to be writing more articles, however.

Dumont (1974) wrote:

> By and large, the acknowledgement of the self-help movement in professional journals is absent, indifferent or hostile, not unlike the perceptions of the professional in general. On the other hand, there is an inevitability about the movement based on a confluence of ideological and cultural forces that suggests it is more than a passing fad in the human services (Dumont, 1974, p. 634).

In the fourteen years since Dumont's statement, his words have proven to be prophetic. The self-help movement has shown itself to be more than a passing fad. It has endured and grown. It has also attracted the interest and attention of large numbers of helping professionals.

The perceptions of these helping professionals toward self-help groups have been the subject of several surveys. In 1978, Levy mailed out a questionnaire to all outpatient psychiatric facilities in the United States, approximately 1,800. He sought to assess the attitudes of professionals toward the efficacy of self-help groups. He felt their attitudes would be manifested in the following ways: the extent to which the professionals utilized self-help groups through referrals, the extent to which the self-help groups were viewed as making referrals, the professionals' evaluation of the effectiveness of the self-help groups, the professionals' judgements of the importance of the potential role self-help groups might play in the mental health delivery system, and an estimate of the probability that the

professionals' agency would try to integrate self-help groups with the agency services.

In 1981, Hermalin and Swift surveyed 244 community mental health centers. They also asked for ways in which the centers could collaborate with self-help groups.

In 1982, Todres surveyed 308 helping professionals in the Toronto area. His personally administered questionnaire included information on the respondent's knowledge of self-help groups in the area, methods of collaboration, and 20 items to assess their attitudes toward self-help groups.

In 1985, Toseland and Hacker surveyed 247 social workers. Their mail questionnaire included information on the respondent's knowledge of self-help groups, methods of collaboration, and 19 items to assess their attitudes toward self-help groups.

All of these authors stressed the importance of self-help groups as a resource which helping professionals could not afford to ignore. They documented a trend of professionals' increasing involvement with self-help groups and increasing positive attitudes. Unfortunately, each study was incomplete. Each used an ad hoc design and created an instrument for each particular study. No information was given on how items were developed. No validity or reliability studies were done on the instruments

designed. No recommendations for further refinement of the instruments were made.

The self-help movement is a phenomenon full of potential for professionals. Foundations and government funding sources are beginning to support research, training and some service grants. The Office of Child Development, part of HEW, provided a grant to Parent's Anonymous which enabled them to begin chapters in almost every state, to develop a national newsletter, and to provide training materials to members. Some form of legal recognition may be forthcoming to self-help groups, networks, and extended families for the role they play in prevention (Borman, 1976). Should funding become more available, research on the self-help movement might be more lucrative for agencies and professionals.

Summary

Self-help groups have early historical origins. They originally formed for the purposes of hunting and gathering food. As civilizations became more developed and basic needs were consistently met, self-help groups expanded into other areas.

The prevailing social and economic conditions of the times have greatly influenced the type and function of self-help groups. Back and Taylor (1976) have suggested that

self-help represents a social movement. Other researchers have suggested that self-help groups developed from unmet needs; as an alternative to services already provided; from widespread feelings of alienation in our society; or from other affiliative arrangements outside kith and kin (Lieberman & Borman, 1976). From a review of the literature on self-help, Killilea (1976) concluded that mutual help organizations are not a simple phenomena or a single movement.

Although self-help groups may be viewed as anti-professional, research does not verify this conclusion (Lieberman, Borman, & Associates, 1979). Many professionals have been involved with self-help groups either by beginning the groups or serving as a consultant to the group.

Self-help groups and professionals have powerful, albeit different, helping techniques (Reissman, 1976). It is possible for both to collaborate in several ways. Each can use the other for referrals, for consultation, or as a mutual learning experience (Gartner & Reissman, 1980).

Due to technological limitations and lack of professional interest little research has been conducted on self-help groups (Lieberman & Borman, 1976). Questions such as how self-help groups function, what is the impact of participation on groups members, and how can self-help

groups work with professionals, have yet to be answered (Killilea, 1976).

With over fifteen million people involved in self-help groups (Evans, 1979), the self-help movement warrants investigation. The developed instrument resulting from this study is a step towards furthering research on self-help groups by assessing helping professionals attitudes toward self-help groups.

CHAPTER 3

METHODOLOGY

The purpose of this study was to develop and validate an instrument to assess helping professionals' experiences with and attitudes toward self-help groups. The research questions, theoretical basis of the instrument, item development, pilot study, field test of the instrument, and limitations of the study are presented in this chapter.

Research Questions

The following research questions were addressed in this study.

1. To what extent does the instrument have content validity?
2. What is the factor structure of the instrument?
3. To what extent is the instrument reliable as demonstrated by internal consistency?

Theoretical Basis

Much of the literature regarding self-help groups is descriptive in nature. Considering the size of the self-help phenomenon, relatively little research has been conducted. Technological limitations with conducting this type of research as well as the lack of instruments are two factors which account for the paucity of research. Due to the lack of research, there were few guidelines to use in the development of the instrument for this study.

The primary sources of guidance were studies conducted by Levy (1978) and by Torres (1982). Levy (1978) developed an instrument to use with mental health professionals which consisted of surveying their use of referrals to or from self-help groups, their evaluation of the effectiveness of self-help groups, and their estimate of the potential role of self-help groups at their agencies. Torres (1982) developed a series of statements to assess the attitudes of helping professionals toward self-help groups. Construct areas were not identified. No rationale for these statements was given. Although both studies were informative, neither researcher conducted item analyses or validation or reliability studies.

In this study, as in Levy's and Torres', the researcher collected data on professionals' attitudes by surveying professionals' experiences with self-help groups and surveying responses to selected statements about self-help

groups. From a review of the literature, it appeared that attitudes toward self-help groups would be based on two components: experiential knowledge and theoretical knowledge. Section I of the instrument was designed to measure the former, Section II the latter.

Item Development

The instrument, Survey of Attitudes Toward and Experiences With Self-Help Groups (SAESHG), is divided into three parts. The first part of SAESHG consists of questions which request information on the educational levels and job titles of the respondents. This information was requested to determine whether the respondents' types of experiences with or attitudes toward self-help groups differed on the bases of their degree levels or job titles. The next part of the SAESHG, Section I, contains a list of 12 methods of collaboration with self-help groups. Respondents are instructed to evaluate the effectiveness of those methods with which they have experience. Information collected from this section was considered as part of the item analysis of the instrument. Methods of collaboration included in this section were selected through a review of the literature. Because all commonly used methods of collaboration were identified through the literature and considered to be under one domain (i.e., the domain of methods of collaboration

with self-help groups), the panel of experts was not asked to place these items in content areas.

An extensive review of the literature on self-help groups was conducted in order to generate items for Section II of the SAESHG, consisting of 55 statements about self-help groups. From this review, five content areas were identified as major categories of information on self-help groups. Using these five areas as a guide, 60 statements were generated, some phrased positively, some negatively. Upon closer scrutinty of the content areas and statements, however, it appeared that by deleting only five statements, two of the content areas could be collapsed. The three remaining areas were: purposes/activities of self-help groups, characteristics of self-help groups, and the relationship of self-help groups to other helpers. Using these three content areas, 55 statements remained. These statements, following Edward's (1957) guidelines for constructing Likert-type attitudinal scales, were designed to evoke affect or opinion rather than cognition or recall. To create uniformity of scoring, all statements which were negatively phrased were re-coded. The following items were re-coded: 5,12,15,18,19,20,23,28,32,33,36,36, and 42.

The SAESHG was reviewed in a preliminary screening by a panel of eight experts who were selected based upon their prominence in the area of research on self-help groups and their willingness to participate in the study. All

panel members were required to have both experiential knowledge of self-help groups as evidenced by their participation in some way with a self-help group and theoretical knowledge as evidenced by their publications about self-help groups. See Appendix A for a listing of panel members names, experience, and relevant publications. The panel was asked to evaluate whether pertinent content areas for item generation had been identified and whether comprehensive items had been generated for each content area. They also evaluated the technical quality of the SAESHG items to determine whether the wording for the items was consistent, and if the items were clear and understandable.

The panel first reviewed Section II of the SAESHG to determine the degree to which the statements represented the domain of attitudes toward self-help groups. All panel members were sent copies of the SAESHG. The panel was asked to choose which of three content areas was most appropriate for the item, if the wording was clear, and if the item appeared appropriate for inclusion. Panel members were asked to return the completed SAESHG within 10 days of receipt in the accompanied, stamped, addressed envelope. The three content areas, processes/activities (P/A), characteristics (C), and relationship to other helpers (ROH), the column undecided/no response (U/NR) and the

panel's responses are shown in Table 3-1. The numbers 0-8 indicate the number of panel members who chose each area.

In assessing the 55 SAESHG items in Section II, a majority of five or more experts believed that 50 of the items were clearly worded and 51 were appropriate. Many of

Table 3-1
Panel of Experts' Evaluations of Item Content in Section II

Item#	Content Area				Wording			Appropriate		
	P/A	C	ROH	U/NR	C	NC	U/NR	Yes	No	U/NR
1	0	2	5	1	4	2	2	7	1	0
2	1	3	3	1	5	0	3	7	1	0
3	5	0	2	1	8	0	0	8	0	0
4	5	1	0	2	4	2	2	6	1	1
5	0	1	5	2	6	0	2	7	1	0
6	3	3	0	2	6	1	1	8	0	0
7	3	4	0	1	6	0	2	7	1	0
8	2	1	0	5	5	1	2	6	0	2
9	3	2	0	3	5	2	1	6	1	1
10	3	0	3	2	6	2	0	6	0	2
11	1	1	4	2	7	1	0	7	0	1
12	5	1	0	2	6	0	2	6	0	2
13	5	1	0	2	5	2	1	5	1	2
14	6	0	0	2	6	2	0	5	1	2
15	0	6	0	2	4	3	1	5	1	2
16	0	0	5	3	6	2	0	6	1	1
17	3	2	0	3	5	2	1	6	0	2
18	2	2	0	4	6	1	1	6	0	2
19	1	3	0	4	7	1	0	8	0	0
20	4	2	0	2	5	2	1	5	1	2
21	0	0	6	2	6	0	2	7	0	1
22	2	2	3	1	5	1	2	5	1	2
23	0	0	6	2	8	0	0	6	1	1
24	4	2	0	2	5	2	1	7	0	1
25	0	4	0	4	5	1	2	5	1	2
26	0	4	4	0	6	1	1	5	1	2
27	4	2	0	2	7	0	1	7	0	1
28	0	3	4	1	8	0	0	7	1	0
29	2	2	0	4	4	2	2	4	1	3
30	3	2	0	3	6	1	1	4	2	2
31	0	0	6	2	8	0	0	8	0	0
32	0	0	6	2	7	0	1	7	0	1
33	1	1	4	2	7	1	0	8	0	0
34	0	0	5	2	2	5	1	3	4	1
35	4	2	0	2	6	2	0	6	2	0

Table 3-1 continued

Item#	Content Area				Wording			Appropriate		
	P/A	C	ROH	U/NR	C	NC	U/NR	Yes	No	U/NR
36	0	4	1	3	6	1	1	6	1	1
37	0	0	6	2	7	1	0	6	1	1
38	0	0	6	2	6	2	0	7	0	1
39	4	2	0	2	7	0	1	7	0	1
40	0	1	5	2	4	4	0	4	3	1
41	2	1	1	4	7	0	1	6	1	1
42	1	0	5	2	7	1	0	6	1	1
43	4	1	0	3	6	0	2	5	1	2
44	2	3	0	3	6	1	1	5	1	2
45	0	0	5	3	6	1	1	5	1	2
46	2	2	0	4	5	0	3	5	0	3
47	0	0	5	3	7	0	1	7	0	1
48	0	0	5	3	6	1	1	6	1	1
49	0	0	5	3	6	1	1	5	1	2
50	0	0	5	3	5	2	1	6	1	1
51	3	1	0	4	5	1	2	5	0	3
52	2	3	0	3	6	1	1	5	1	2
53	3	2	0	3	5	1	2	5	0	3
54	1	4	0	3	6	1	1	6	0	2
55	0	0	5	3	6	0	2	5	0	3

Note. P/A = purposes/activities; C = characteristics; ROH = relationship to other helpers; U/NR = undecided/no response.

the panel members, however, commented that they did not like the content areas and believed it was too difficult to distinguish in which content area an item should be placed. Specifically, many of the panel members believed it was difficult to choose between the content areas purposes/activities, and characteristics. Some of the panel members marked all three areas for the same item, others refused to choose any area.

The majority of the panel members agreed on the same content area for 24 of the items. Thirty-one items had no clear-cut majority of responses. If the majority opinion of

the panel was that the item was appropriate, then the item was kept regardless of whether the panel could agree on the content area for the item. A majority was considered to be five of the eight panel members.

One panel member chose the content areas but not whether the item was clearly worded or appropriate. Another panel member was inconsistent in responding, often omitting the content areas and only indicating if the item was appropriate or not. Six of the panel members consistently evaluated each item across all categories. Based upon the panel's evaluation, items 34 and 40 were omitted. The revised SAESHG contained 53 items in Section II. A Likert-type scale was selected as the response format for the items. It ranged from Strongly Disagree (1) to Strongly Agree (5). After the item revision was completed, the instrument was mailed back to panel members. The panel was asked to review each section and to comment on the format of the questions, wording, appropriateness, comprehensiveness of items, and ease of completion. Comments from the panel were very favorable. No revisions were required in Section I and only minor revisions were made in Section II prior to the pilot study. The panel also was requested to complete the revised SAESHG. This provided a method of assessing their experience and attitudes toward self-help groups.

Pilot Study

The purpose of the pilot study was to determine the suitability of the item format, the appropriateness of the items, and the ease of completion of the instrument. Since the field test involved a large mail-out, the pilot study served as a screening device for identifying problems respondents might have completing the SAESHG.

A class of graduate students in Counselor Education at Hunter College in New York City was selected for the pilot study. This class was chosen because of their similarity to the research sample and their willingness to participate in the study. Permission was obtained from the professor to ask the students to participate in the study. All ten students agreed to participate. They were given the SAESHG, asked to complete it and mail it back within two weeks. They were also asked to make any comments or write any questions they had on the instrument. All completed surveys were received during the first week.

The educational level of the students was as follows: five had Bachelor's degrees, four had Master's degrees, and one had a Specialist in Education. Three were employed as counselors, four as teachers, one as an administrator, and two in other fields. Regarding training with self-help groups, five had had college courses, one had had a seminar, one had had practical experience, and three had had no training.

Regarding experience with self-help groups, four had experience as participants, four had experience as observers, and two had experience as leaders. Two of the students had no experience with self-help groups, six had only one type of experience, one had two types, and one had three types of experience with self-help groups.

At the time of the pilot study, the SAESHG had two parts to Section I. Items on both parts were identical. Respondents who had experience with self-help groups were requested to indicate those areas in which they had worked with self-help groups by evaluating the effectiveness of the collaboration using a Likert-type scale. Respondents who had no experience with self-help groups were requested to indicate the probability of their collaborating in the ways listed by using the same scale.

Although eight of the ten students gave at least one type of experience with self-help groups, none completed part one of Section I of the SAESHG. No one commented on why they did not complete this section. One possibility is that they did not feel sufficiently experienced to evaluate self-help groups in the manner requested in that section. Another possibility is that they were confused over whether to complete part one or part two since all the students with experience completed part two rather than part one.

Nine of the ten students completed part two of Section I. Part two of Section I requested respondents with no

experience with self-help groups to indicate the probability of their collaborating with self-help groups in various ways by using a Likert type scale. Six of the nine indicated they would collaborate with self-help groups by making referrals to the groups and receiving referrals from the groups. Four of the nine indicated they would collaborate by providing training to a self-help group and conducting research on a self-help group. Three of the nine indicated they would probably not collaborate by conducting research on a self-help group.

While this information was useful in that it indicated a strong willingness in some specific areas to collaborate with self-help groups, it was possibly misleading since respondents with experience had completed the section for respondents without experience. Because the study was to focus on the actual experience the respondents had with self-help groups, part two of Section I was omitted from the SAESHG prior to the field test. This resulted in a shorter instrument which could be completed in less time. It also reduced confusion over which part of Section I to complete.

The mean, standard deviation, and respondent numbers for each item in Section II is given in Table 3-2. With the exception of items 17, 20, 28, 30, 43, 46, and 48, all participants responded to each item.

Table 3-2
Section II Results of Pilot Study

Item#	Mean	s.d.	N
1	3.5	0.9	10
2	3.3	0.6	10
3	4.8	0.4	10
4	4.8	0.4	10
5	3.6	1.0	10
6	3.0	0.9	10
7	3.8	0.7	10
8	4.5	0.7	10
9	4.3	1.0	10
10	3.7	1.0	10
11	2.6	0.6	10
12	4.3	1.2	10
13	3.8	0.9	10
14	3.4	0.9	10
15	4.2	1.1	10
16	3.3	1.1	10
17	2.8	0.9	9
18	4.8	0.4	10
19	3.2	1.1	10
20	3.1	0.7	9
21	2.4	0.8	10
22	3.5	0.8	10
23	2.8	0.9	10
24	4.1	0.7	10
25	3.1	0.8	10
26	2.0	0.9	10
27	3.9	1.	10
28	3.1	1.4	9
29	3.5	1.4	10
30	3.3	0.9	9
31	3.7	0.4	10
32	3.2	1.2	10
33	3.1	0.7	10
34	4.3	0.9	10
35	4.0	1.2	10
36	2.5	0.8	10
37	4.2	0.6	10
38	4.2	0.9	10
39	2.6	0.9	10
40	2.4	0.7	10
41	2.6	1.0	10
42	3.8	0.9	10
43	3.2	0.4	9
44	4.4	0.5	10
45	4.2	0.6	10
46	3.1	0.9	9
47	4.5	0.5	10

Table 3-2 Continued

Item #	Mean	s.d.	N
48	2.7	1.3	9
49	4.0	0.6	10
50	3.9	0.7	10
51	3.2	0.9	10
52	3.9	0.5	10
53	3.9	0.7	10

The means ranged from 2.0 to 4.8. The standard deviations ranged from .4 to 1.4. Five items, 3,4,8,18,and 47, had means greater than or equal to 4.5. These items all pertained to attributes of a self-help group except item 47 which stated that helping professionals should support self-help groups. Four items (21,26,36,and 40) had means less than or equal to 2.5. These items all pertained to the relationship of self-help groups to helping professionals or traditional therapy.

Panel of Experts' Item Responses

After evaluating the items and format of the instrument, the panel of experts was requested to complete the SAESHG to provide a comparison with the pilot study and field test. Their responses also were requested to ascertain the degree of variability in their responses. Six panel members completed both sections of the SAESHG. One member did not respond to questions on educational level, training, or experience, but did complete Section II. One panel member did not return the survey.

Of the six panel members, five had Ph.D.s and one had a D.S.W. Four were professors, one was a counselor/therapist, and one an administrator. All six had training through self-directed study and practical experience. Two members also had training through a seminar/workshop and two through assisting with research. Experience with self-help groups was divided among four members who had been participants in self-help groups, five were interested observers, five were consultants, five were researchers, two were leaders and one was an administrator of a national self-help group. Five of the members had training and experience with self-help groups in at least three different areas.

Regarding Section I, the following means of collaboration were rated as very effective by at least three of the six panel members: using self-help groups as a source of information, forming an advocacy group or coalition with a self-help group, serving as a consultant to a self-help group, using a self-help group as consultants, and conducting research on a self-help group or phenomenon. One panel member rated using self-help groups as a source of information as a very ineffective means of collaboration. One panel member also rated receiving referrals from self-help groups, integrating self-help group members into committees, boards, etc., and sharing facilities with self-help groups as somewhat ineffective means of collaboration.

Seven panel members completed Section II of the SAESHG. Their responses are presented in Table 3-3.

Table 3-3
Section II Results from the Panel of Experts

Item#	Mean	s.d.	N
1	2.4	0.7	7
2	4.1	0.6	7
3	4.8	0.3	7
4	3.8	1.0	7
5	3.5	0.7	7
6	3.5	1.1	6
7	3.4	0.5	7
8	5.0	0.0	7
9	4.0	0.6	6
10	3.2	0.9	7
11	2.1	0.8	7
12	4.7	0.5	7
13	4.1	0.6	7
14	4.2	0.5	7
15	4.1	1.0	7
16	2.8	1.5	7
17	4.2	1.0	7
18	4.5	0.7	7
19	3.8	0.6	7
20	3.0	0.8	6
21	3.5	1.3	7
22	3.3	1.4	6
23	4.7	0.5	7
24	4.7	0.5	7
25	3.4	0.5	7
26	4.7	0.7	7
27	2.5	0.5	7
28	2.8	1.1	6
29	3.0	1.3	7
30	4.0	0.9	7
31	1.4	0.7	7
32	3.0	1.0	6
33	2.8	1.0	7
34	4.5	0.5	7
35	4.4	0.7	7
36	3.5	0.9	7
37	4.2	1.4	7
38	4.2	0.7	7
39	2.2	1.5	7
40	2.6	0.8	5
41	3.8	0.4	6
42	3.6	0.9	6

Table 3-3 Continued

Item#	Mean	s.d.	N
43	3.6	0.5	6
44	4.5	0.8	6
45	4.2	0.7	7
46	3.7	0.9	7
47	4.0	1.3	7
48	3.6	0.9	6
49	4.4	0.5	7
50	3.7	1.2	7
51	3.3	0.7	6
52	4.1	0.7	6
53	4.0	0.6	5

The means ranged from 1.4 to 5. The standard deviations ranged from .3 to 1.5. Nine of the items (3, 8, 12, 18, 23, 24, 27, 34, and 44) had means greater than or equal to 4.5. All the items pertained to attributes of a self-help group except item 23, self-help groups should be started by a helping professional. Three of the items (3,8,and 18) were also rated the highest by the pilot study.

Four items (1,11,31,and 39) had means less than or equal to 2.5. None of these items were rated that low in the pilot study. All items pertained to the relationship of self-help groups with helping professionals or other agencies.

Although several items appeared to have little variance, as evidenced by standard deviations below .50, no items were deleted at this point. Because the pilot study sample was so small and the panel of experts so experienced

with self-help groups, it seemed premature to delete items based on those responses.

Field Test

The purpose of the field test of the SAESHG was to answer the three research questions posed by the study: does the instrument have content validity, what is the factor structure of the instrument, and is it reliable? A diverse group of helping professionals, members of the American Mental Health Counselors Association (AMHCA), was chosen as the sample population. This group was selected because a population was needed which possessed direct experience or familiarity with self-help groups and which represented differing types of professionals likely to use self-help groups. A computerized mailing list of every 14th name on the mailing list was provided by AMHCA. A total of 1,000 names of AMHCA members was included on the mailing list.

Once permission was secured from AMHCA to survey their members, the SAESHG was mailed to the 1,000 AMHCA members randomly selected. The questionnaire method was chosen because it makes information from a large group of people more accessible. It is a method which allows objectivity in evaluating responses. It eliminates interpretive problems. It insures anonymity for the respondent, and as a result, encourages honest and valid responses (Isaac & Michael, 1971; Kerlinger, 1973).

Included with the instrument was a letter of transmittal explaining the purpose of the study, instructions for completion, and a stamped, return-addressed envelope. A six week period immediately following the mail-out was chosen as the time frame for inclusion in the study. A total of 410 instruments were received during that period. The return rate of 41% was high enough to provide 145 more surveys than required for the data analysis used in the study. An additional 14 completed surveys were received after the cut-off date, bringing the overall return rate to 42.4%.

Content validity of the SAESHG was determined by the panel of experts chosen to review the instrument and evaluate whether the items were appropriate. A list of the panel members is found in Appendix A. The panel was asked to evaluate whether relevant content areas for item generation had been identified and whether comprehensive items had been generated for each content area. They also evaluated the technical quality of the items to determine whether the wording was appropriate, and if the items were clear and understandable. As discussed in Item Development, the panel believed most items were clear and appropriate. Refer to Table 3-1 for the evaluations.

Based on the panel's responses and suggestions, items were revised or discarded. After the item revision was completed, the instrument was mailed to panel members and they were asked to complete the instrument. The panel was

asked to review each section and to comment on the format of the questions, wording, appropriateness, comprehensiveness of items, and difficulty completing the instrument. Based on their comments, the SAESHG was revised further.

Factor analyses were completed for both sections of the SAESHG, Section I surveying experiential knowledge, and Section II surveying theoretical knowledge. All 410 completed instruments were hand scored and the data subsequently transferred to a computer disc. An alpha level of .05 was the criterion set for statistical significance evaluations. Principal Components factor analyses using an oblique rotation was completed using the Statistical Package for the Social Sciences. The mean and standard deviation were calculated for each item and for the total scores. Factor loadings were reviewed for the clearest seperation of factors.

The internal consistency of the instrument was computed to provide a measure of reliability for the SAESHG. Coefficient Alpha analyses were employed to assess internal consistency.

Limitations of the Study

One limitation of this study was that the data collected were based upon self reports which could be limited by the respondents' honesty and/or security, the accuracy of the respondents' memory, and whether the

respondents understood the items. Another limitation was the subject selection. Only one group of helping professionals (AMHCA) was surveyed. Since this was a descriptive study, the only threat to external validity was in subject selection (Isaac & Michael,1971). Because only one helping professional group was surveyed, it may not be possible to generalize to all helping professionals. It is possible that the AMCHA members who chose not to respond had different views from those who did respond (Babbie, 1973).

CHAPTER 4

RESULTS AND DISCUSSION

Results of the Study

The purpose of this study was to develop and validate an instrument to assess helping professionals' experiences with and attitudes toward self-help groups. The three research questions in the study were (a) to what extent does the instrument have content validity, (b) what is the factor structure of the instrument and (c) to what extent is the instrument reliable? The results of the study presented in this chapter include information on the sample, content validity, construct validity, and reliability.

Sample

Instruments were mailed to 1,000 randomly selected members of AMHCA. Instruments returned during the first three weeks following the mail-out were included in the study. A total of 410 instruments were received during this period. The 41% return rate was relatively high for a mail-out and yielded more than the 265 surveys necessary for the

study. Another 14 instruments were received after the cut-off date, increasing the overall return rate to 42.4%.

It should be noted that 44 participants only completed the biographical questions and did not respond to any items in Section I, the Experience Scale, or Section II, the Attitude Scale. Apparently, after reading the directions for Section I, instructing only those participants with experience with self-help groups to complete it, these 44 respondents did not continue to Section II.

Information about the respondents who completed both sections of the SAESHG is provided in Table 4-1. Because of the high response rate to Section II, the Attitude Scale, as shown in Table 4-3, analyses were conducted using 351 surveys. This includes the 288 surveys in which all items were completed and the 63 surveys in which at least 50 of the 53 items were completed.

Table 4-1
Demographic Characteristics of Sample

Zip Code		N	% of Total
Area 0	East Coast	40	11.4
Area 1	East Coast	46	13.1
Area 2	East Coast	36	10.3
Area 3	East Coast	51	14.5
Area 4	Mid-West	34	9.7
Area 5	Mid-West	25	7.1
Area 6	Mid-West	32	9.1
Area 7	Far West	23	6.6
Area 8	Far West	30	8.5
Area 9	Far West	31	8.8
No Area Given		3	.9

Table 4-1 Continued

Educational Level		
Bachelor	13	3.7
Master	236	67.2
EdS	13	3.7
PhD or EdD	74	21.1
Other	13	3.7
Missing	2	.6
Job Title		
Counselor/Therapist	254	72.4
Teacher	12	3.4
Administrator	25	7.1
Other	29	8.3
Missing	31	8.8
Types of Experience with Self-Help Groups		
No experience	26	7.4
1 type	79	22.5
2 types	125	35.6
3 types	88	25.1
4 or more types	33	9.4
Amount of Training with Self-help Groups		
No Training	4	1.1
1 kind	113	32.2
2 kinds	83	23.6
3 kinds	103	29.4
4 kinds	48	13.7

The geographic distribution of participants seems to follow the general population distribution of the United States. The majority (49.3%) live within the East Coast region, in postal zip code areas 0-3, including all the Atlantic Seaboard. The Mid-West region, areas 4-6, accounts for 25.9% of the sample. The Far West, areas 7-9, accounts for 23.9%.

As might be expected in a professional organization, 88.3% had graduate degrees. The majority (67.2%) had Master's degrees. Most of the participants (72.4%) listed their job title as counselor/therapist. The remaining participants were divided between administrators, teachers, other, or not given.

Only 7.4% of the participants had no experience with self-help groups. Almost one quarter of the participants (22.5%) had experienced one type of collaboration with self-help groups. A surprisingly large number (70.1%) had experienced two or more types of collaboration with self-help groups. Regarding training with self-help groups, only 1.1% had no training, 32.2% had one kind of training, and 66.7% had two types of training or more. Demographic characteristics of the AMHCA membership were unavailable for this study. It is assumed, however, that the AMHCA members in this study were representative of all AMHCA members because they were randomly selected.

Item Analyses

Item analyses were performed on the items in both sections of the SAESHG. The means and standard deviations for items in both sections of SAESHG are shown in Table 4-2.

Table 4-2
Means And Standard Deviations For All Items

Item Number	Mean	s.d.	N
Section I			
1	4.08	.98	302
2	3.61	1.07	265
3	4.10	.89	304
4	3.31	1.16	239
5	3.54	1.12	270
6	3.20	1.14	211
7	3.14	1.07	219
8	3.88	1.04	251
9	3.44	1.12	238
10	3.89	1.09	253
11	3.31	1.17	231
12	3.02	1.24	195
Section II			
1	3.03	1.19	362
2	3.68	1.13	361
3	4.51	.82	365
4	4.39	.84	363
5	2.82	1.03	361
6	3.32	.94	360
7	3.67	.77	360
8	4.48	.81	364
9	4.11	.80	361
10	2.91	1.24	363
11	2.41	.99	362
12	4.37	.92	364
13	3.97	.96	363
14	3.56	1.06	362
15	4.35	.93	363
16	3.10	1.18	357
17	3.94	.88	355
18	4.51	.80	360
19	3.55	1.09	360
20	3.14	1.00	351
21	2.38	1.10	360
22	2.75	1.16	356
23	3.26	1.14	358
24	4.25	.84	359
25	2.66	1.02	360
26	2.14	.91	355
27	4.14	.87	359
28	3.22	.98	356
29	2.91	1.26	361
30	3.49	1.04	353
31	3.75	.93	360
32	2.30	1.17	359
33	3.16	.99	355

Table 4-2 Continued

Item Number	Mean	s.d.	N
Section II			
34	4.15	.75	359
35	4.11	.97	358
36	2.28	1.05	356
37	4.22	.90	354
38	4.19	.72	358
39	1.84	1.10	358
40	2.14	.90	359
41	2.69	1.10	353
42	3.74	.99	361
43	3.76	.92	354
44	4.19	.75	364
45	4.10	.86	362
46	2.93	1.07	359
47	4.30	.82	361
48	2.71	1.05	354
49	3.59	.89	361
50	3.87	.72	361
51	3.27	1.03	355
52	3.64	.90	361
53	3.92	.86	354

Section I consisted of items 1 through 12, listing 12 methods of collaboration between helping professionals and self-help groups. Respondents were asked to evaluate the effectiveness of those methods with which they had experience by using a Likert-type scale. Possible responses ranged from 1, very ineffective, to 5, very effective. Table 4-2 indicates that the highest number of respondents chose item 3, indicating experience making referrals to self-help groups. The data in Table 4-2 also indicate that 302 respondents chose item 1, indicating they used self-help groups as a source of information. These two areas of

collaboration also had the highest mean (4.1) rating them the most effective method of collaborating as well.

The lowest number of responses (195) was to item 12, conducting research on self-help groups or phenomenon. The remaining 10 items had means ranging from 3.89 to 3.02. The item means for Section I were at the high end, ranging from 3.02 to 4.10. There was considerable variability, however, in responses as demonstrated by the range of the item standard deviations from .89 to 1.24.

Section II consisted of 53 statements about self-help groups which respondents were asked to rate, again using a Likert-type scale. The number of responses per item ranged from a high of 365 responses to item 3, self-help groups are an important resource in meeting the mental health needs of society, to a low of 315 to item 20, self-help groups encourage members to conform to social norms. The means ranged from a high of 4.51 for item 18, self-help groups are not effective to a low of 1.85 for item 39, self-help groups should be regulated by the government for consumer protection. Variance in response to the items was indicated by the item standard deviations ranging from .72 to 1.27. The participants' response rates for Section II, the Attitude Scale, are shown in Table 4-3.

Table 4-3 Participants' Response Rates to Attitude Scale

# of Items Omitted	Frequency	%	Cum %
0	288	70.2	70.2
1	40	9.8	80.0
2	15	3.7	83.7
3	8	2.0	85.6
4	1	.2	85.9
5	1	.2	86.1
6	1	.2	86.3
8	1	.2	86.6
11	1	.2	86.8
13	1	.2	87.1
19	1	.2	87.3
20	1	.2	87.6
21	1	.2	87.8
24	1	.2	88.0
25	4	1.0	89.0
43	1	.2	89.3
53	44	10.7	100.0
TOTAL	410	100.0	100.0

Mean 6.58
Standard Deviation 16.58

The participants' responses to the items in Section I, the Experience Scale, are provided in Table 4-4.

Table 4-4 Frequency and Value Distribution of Items in Section I

1. Use self-help groups as a source of information.

Value Label	Value	Freq	Percent
Very Ineff	1	10	2.8
Somewhat Ineff	2	15	4.3
Neither	3	27	7.7
Somewhat Eff	4	126	35.9
Very Eff	5	110	31.3
No Response	9	63	17.9

Mean 4.08 Standard Deviation .99

Table 4-4 Continued
2. Publicize self-help groups active in the area.

Value Label	Value	Freq	Percent
Very Ineff	1	13	3.7
Somewhat Ineff	2	28	8.0
Neither	3	55	15.7
Somewhat Eff	4	108	30.8
Very Eff	5	48	13.7
No Response	9	99	28.2

Mean 3.59 Standard Deviation 1.07

3. Make referrals to self-help groups.

Value Label	Value	Freq	Percent
Very Ineff	1	6	1.7
Somewhat Ineff	2	14	4.0
Neither	3	26	7.4
Somewhat Eff	4	140	39.9
Very Eff	5	103	29.3
No Response	9	62	17.7

Mean 4.11 Standard Deviation .90

4. Share facilities with self-help groups.

Value Label	Value	Freq	Percent
Very Ineff	1	24	6.8
Somewhat Ineff	2	18	5.1
Neither	3	93	26.5
Somewhat Eff	4	51	14.5
Very Eff	5	44	12.5
No Response	9	121	34.5

Mean 3.32 Standard Deviation 1.18

5.Receive referrals from self-help groups.

Value Label	Value	Freq	Percent
Very Ineff	1	21	6.0
Somewhat Ineff	2	22	6.3
Neither	3	58	16.5
Somewhat Eff	4	108	30.8
Very Eff	5	47	13.4
No Response	9	95	27.1

Mean 3.54 Standard Deviation 1.13

Table 4-4 Continued
6. Form an advocacy group or coalition with a self-help group.

Value Label	Value	Freq	Percent
Very Ineff	1	25	7.1
Somewhat Ineff	2	22	6.3
Neither	3	70	19.9
Somewhat Eff	4	67	19.1
Very Eff	5	22	6.3
No Response	9	145	41.3

Mean 3.19 Standard Deviation 1.15

7. Integrate self-help group members into committees,boards,etc.

Value Label	Value	Freq	Percent
Very Ineff	1	23	6.6
Somewhat Ineff	2	28	8.0
Neither	3	75	21.4
Somewhat Eff	4	73	20.8
Very Eff	5	15	4.3
No Response	9	137	39.0

Mean 3.14 Standard Deviation 1.08

8. Serve as a consultant to a self-help group.

Value Label	Value	Freq	Percent
Very Ineff	1	14	4.0
Somewhat Ineff	2	11	3.1
Neither	3	33	9.4
Somewhat Eff	4	113	32.2
Very Eff	5	70	19.9
No Response	9	110	31.3

Mean 3.89 Standard Deviation 1.06

9. Use a self-help group as consultants.

Value Label	Value	Freq	Percent
Very Ineff	1	20	5.7
Somewhat Ineff	2	20	5.7
Neither	3	61	17.4
Somewhat Eff	4	93	26.5
Very Eff	5	36	10.3
No Response	9	121	34.5

Mean 3.46 Standard Deviation 1.12

Table 4-4 Continued
10. Provide training to a self-help group.

Value Label	Value	Freq	Percent
Very Ineff	1	17	4.8
Somewhat Ineff	2	7	2.0
Neither	3	42	12.0
Somewhat Eff	4	102	29.1
Very Eff	5	78	22.2
No Response	9	105	29.9

Mean 3.88 Standard Deviation 1.10

11. Receive training from a self-help group.

Value Label	Value	Freq	Percent
Very Ineff	1	23	6.6
Somewhat Ineff	2	28	8.0
Neither	3	62	17.7
Somewhat Eff	4	77	21.9
Very Eff	5	34	9.7
No Response	9	127	36.2

Mean 3.32 Standard Deviation 1.18

12. Conduct research on self-help group or phenomenon.

Value Label	Value	Freq	Percent
Very Ineff	1	36	10.3
Somewhat Ineff	2	13	3.7
Neither	3	76	21.7
Somewhat Eff	4	41	11.7
Very Eff	5	25	7.1
No Response	9	160	45.6

Mean 3.03 Standard Deviation 1.25

The methods of collaboration selected as very effective were using self-help groups as a source of information (item 1), making referrals to self-help groups (item 3), and providing training to a self-help group (item 10). The methods chosen least effective were forming an advocacy group or coalition with a self-help group (item 6)

and conducting research on a self-help group or phenomenon (item 12).

The methods of collaboration which had the lowest percentage of no response, less than 20%, indicating the most experience, were using self-help groups as a source of information (item 1), and making referrals to self-help groups (item 3). The highest percentage of no response, more than 40%, indicating areas of least experience, were forming an advocacy group or coalition with a self-help group (item 6), and conduct research on self-help group or phenomenon (item 12).

Content Validity

Although the panel of experts chosen to evaluate the items generated for the SAESHG rated the items appropriate, they had difficulty choosing which item was in which content area for Section II, the Attitude Scale with 53 items. This was especially true in discriminating between the areas of purposes/activites and characteristics. The panel could not decide between purposes/activities and characteristics for 31 items. For the content area relations to other helpers, 17 items were developed, and 15 of these were chosen for that area by the panel. Rather than discard items which the panel had agreed were appropriate for the instrument because of confusion over

which content area the item should be placed in, all items were retained. After the field test, factor analyses were completed so that items could be seperated by empirical methods.

Construct Validity

Factor analyses were completed on both sections of the SAESHG using responses from the field study to determine how items loaded in both Section I and Section II. Regarding Section I, the Experience Scale, a factor analysis using principal component analysis was completed. Because items were designed for one scale, a decision was made a priori to force items to one factor. As can be see in Table 4-5, all items have a factor loading of at least .54.

Table 4-5
Principal Component Analysis of Section I, Items 1-12

Item #	Factor Loading
1	.55287
2	.63918
3	.55763
4	.59291
5	.60604
6	.71064
7	.61656
8	.54512
9	.64949
10	.65004
11	.62643
12	.60665

A principal component analysis using an oblique rotation was used on Section II, the Attitude Scale. A .30 loading cut-off point was used to select items for factor loadings. It was believed a priori that items comprised three separate scales. The factor analysis used to explore this possibility was a principal component analysis for a three factor solution. The resulting factor loadings are shown in Table 4-6.

Table 4-6
Factor Loadings: Principal Component Analysis, Oblique

Item#	<.3	Factor 1	Factor 2	Factor 3
1			.33162	
2	X			
3		.61759		
4		.59257		
5				.36092
6	X			
7		.55139		
8		.56372		
9		.41192		
10			.47340	
11	X			
12		.67783		
13		.59428		
14		.34812		
15		.39778		
16				-.64683
17		.58893		
18		.76605		
19		.34280		
20	X			
21			.36025	.45434
22			.51548	
23				.65330
24		.45699		
25			.49758	
26			.52298	
27		.36324		
28	X			
29		.41990		

Table 4-6 Continued

Item#	<.3	Factor 1	Factor 2	Factor 3
30		.36863		
31		.54763		
32			.38013	
33	X			
34		.58914		
35		.36185		
36				.71750
37		.30359		
38		.71734		
39		-.31153		
40			.64729	
41	X			
42		.40963		.30643
43			.43255	
44		.70545		
45		.58375		
46	X			
47		.71982		
48			.41441	
49		.52232		
50		.58460		
51		.32492	.32133	
52		.57143		
53		.63732		

Based on the loading cut-off point of .30, the following items were not retained: 2, 6, 11, 20, 28, 33, 41, and 46. Item 37 just met the cut-off criteria with a loading of .30359.

A principal component analysis with a varimax rotation also was done using a three factor solution with very similar results. Table 4-7 provides the factor loadings for each item.

Table 4-7
Factor Loadings: Principal Component Analysis, Varimax

Item#	<.3	Factor 1	Factor 2	Factor 3
1			.34789	
2	X			
3		.61405		
4		.58552		
5				.34684
6			.30386	
7		.54905		
8		.54354		
9		.41197		
10			.48618	
11	X			
12		.66787		
13		.59926	.32267	
14		.35651		
15		.38670		
16				-.64244
17		.59120		
18		.75954		
19		.33960		
20	X			
21			.34811	.42120
22			.52396	
23				.66358
24		.45474		
25			.50565	
26			.50307	
27		.36073		
28	X			
29		.42511		
30		.36926		
31		.54715		
32			.37304	
33	X			
34		.59026		
35		.36755		
36				.70257
37				.31117
38		.71753		
39		-.30012		
40			.64163	
41	X			
42		.39612		.35337
43			.41485	
44		.70278		
45		.58115		
46	X			
47		.71455		

Table 4-7 Continued

Item#	<.3	Factor 1	Factor 2	Factor 3
48			.42592	
49		.52457		
50		.58588		
51		.33341	.34456	
52		.57382		
53		.63406		

A comparison of Table 4-6 and Table 4-7 reveals that for both analyses items 2, 11, 20, 28, 33, 41, and 46 had loadings less than .3. Item 6 did load on factor 2 using the varimax rotation, but since it loaded at .30386, this item cannot be considered definitive. Comparing the loadings on Factor 1, all the items were the same for both with the exception of item 37 which loaded on the oblique rotation at .30359. Due to the low value of this loading, item 37 could be discarded. On Factor 2, the same items loaded with the exception of 6 and 13. Item 13 had a higher value on Factor 1. On Factor 3, the same items loaded with the exception of items 9 and 37, both of which had values less than .312. This comparison of Table 4-6 and Table 4-7 appears to further indicate that items 2, 11, 20, 28, 33, 41, and 46 could be omitted from the instrument since they did not load on any factor, and that the remaining 46 items are loading on the same factors, with few exceptions.

A review of the items showed that many loaded as expected. Some of the items which did not load seemed to be

related to each other. Since one explanation of the difficulty of the panel of experts to choose between the three hypothesized factors was that there was another factor within one of the possible three factors, a principal component analysis was conducted to investigate if there was a fourth factor. Results are shown in Table 4-8.

Table 4-8 Factor Loadings: Principal Component Analysis, Varimax Rotation

Item#	<.3	Factor 1	Factor 2	Factor 3	Factor 4
1					.44908
2					-.55732
3		.62001			
4		.58890			
5					.55298
6			.34638		
7		.53849			
8		.54449			
9		.39592			
10			.40960		.41737
11					-.39497
12		.67632			
13		.61545			
14		.35795			
15		.39344			
16				-.72561	
17		.58809			
18		.76679			
19		.35521			
20					.34403
21			.36139	.62873	
22			.51187		
23				.68719	
24		.45528			-.36059
25			.50719		
26			.53884		
27		.34875			
28	X				
29		.42199			
30		.36669			
31		.56876			
32					.41503
33	X				
34		.59493			

Table 4-8 Continued

Item#	<.3	Factor 1	Factor 2	Factor 3	Factor 4
35		.36798			
36				.70528	
37		.30085			
38		.72900			
39		-.30664			
40			.60429		
41	X				
42		.40624			
43			.43989		
44		.70972			
45		.59066			
46	X				
47		.71987			
48			.42064		
49		.53034			
50		.58988			
51		.34030			.35097
52		.57591			
53		.64653			
Eigen value		9.65123	3.15474	2.68013	2.28233
Pct of Variance		18.2	6.0	5.1	4.3

Of the items which had not loaded previously across three factors, items 28, 33, 41, and 46 also failed to load across four factors. Items 2, 11, and 20, which had also failed to load previously, now loaded on factor 4. In addition, items 1,5,10,24,32,and 51, which had previously loaded on other factors, now loaded on factor 4. This completed the factor analyses on Section II.

At this point a Scree Test was used to assist in selecting the three or four factor solution for subsequent reliability studies. As illustrated in Figure 1, the elbow occurring at factor 4 indicates that the four factor solution is the more desirable one.

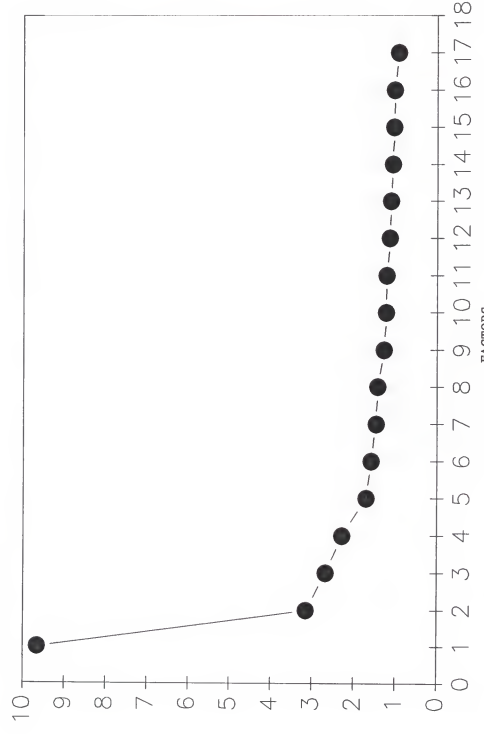

FIGURE 1. SCREE TEST

Factor 1 consisted of 31 items with factor loadings ranging from .30 to .76. The content of these items pertained to characteristics of self-help groups including benefits to members, strengths, and importance of self-help groups. Factor 2 consisted of 10 items with factor loadings ranging from .35 to .60. The content of these items pertained to contrasts between self-help groups and traditional therapies.

Factor 3 consisted of 4 items with factor loadings from .63 to .73. Items related to the involvement of a helping professional with a self-help group. Due to the high negative loading of item 16, it was omitted prior to the reliability analysis for this factor.

Factor 4 consisted of 9 items with factor loadings from .34 to .56. The content of these items related to comparisons between self-help and professional services, and functions of self-help groups. Items loading on this factor did not seem to be as related in content as on the other factors.

Reliability

As mentioned previously, data analyses were completed using 351 participants, or those participants who responded to 50 or more items in Section II. Based on the factor analytic solutions, reliability studies were conducted on Section II for factors 1, 2, 3, and 4. The

results of these studies are presented in Tables 4-9 through 4-12.

Table 4-9
Reliability Analysis for Factor One

Item#	Alpha if Item Deleted
3	.9016
4	.9025
7	.9033
8	.9035
9	.9055
12	.9007
13	.9008
14	.9056
15	.9058
17	.9020
18	.8994
19	.9063
24	.9045
27	.9065
29	.9061
30	.9062
31	.9020
34	.9023
35	.9062
38	.9003
42	.9056
44	.9005
45	.9021
47	.9001
49	.9029
50	.9021
51	.9057
52	.9019
53	.9009

Reliability Coefficients 29 items
Alpha = .9062 Standardized Item Alpha = .9128

Table 4-10
Reliability Analysis for Factor Two

Item#	Alpha if Item Deleted
6	.6222
10	.6059
22	.5827
25	.5903
26	.6214
40	.5839
43	.6405
48	.6160

Reliability Coefficients 8 items
Alpha = .6401 Standardized Item Alpha = .6420

Table 4-11
Reliability Analysis for Factor Three

Item#	Alpha if Item Deleted
21	.6296
23	.5646
36	.4827

Reliability Cofficients 3 items
Alpha = .6567 Standardized Item Alpha = .6583

Table 4-12
Reliability Analysis for Factor Four

Item#	Alpha if Item Deleted
1	.4302
5	.4816
10	.3923
20	.5297
32	.4287
51	.4539

Reliability Coefficients 6 items
Alpha = .5581 Standardized Item Alpha = .5601

Based upon the results of the factor analyses and the reliability analyses conducted, as well as a review of the content of the items, several items were dropped. Items 9, 15, 24, 27, and 35 were dropped because of poor item dispersion as evidenced by means <2.0 or >4.0 and loadings of .40 or less. The content of these items also appeared to be more cognitive than affective. Additional items which were dropped were: 2, 11, 16, 28, 33, 37, 39, 41, and 46. Remaining items had loadings of .34 or greater and standard deviations >.72. The items which were retained for the final form of the SAESHG are in Table 4-13.

Discussion of the Results

Content Validity

An exhaustive review of the literature on self-help groups was conducted before the SAESHG items were developed. Certain broad areas were identified through this literature search which seemed to encompass most of the information available about self-help groups. Specific items were developed for the SAESHG based on these broad areas. Once items for the SAESHG were developed, these items were submitted to the panel of experts for evaluation. Candidates for the panel of experts also were identified through a review of literature. Only those authors with experiential knowledge of self-help groups were asked to be members of the panel of experts.

Table 4-13

Final Factors for SAESHG

Factor 1

Item #	Factor Loadings
3. SHGS are an important resource in meeting the mental health needs of society.	.63
4. SHGS foster support networks throughout the population.	.59
7. SHGS have positive effects on family relationships.	.54
8. SHGS are not a passing fad.	.54
12. SHGS are more harmful than beneficial.	.68
13. A SHG is a powerful change agent.	.62
14. SHGS serve to educate the general publi	.36
17. SHGS empower their individual member	.59
18. SHGS are not effective.	.77
19. SHGS do not reach those most in need of assistance.	.36
29. Anyone can benefit from a SHG.	.42
30. SHGS "normalize" the needs of their members.	.37
31. Professionals have a great deal to learn from SHGS.	.57
34. SHGS encourage members to give, not just to receive.	.59
38. SHGS increase members' abilities to help themselves.	.73
42. Most SHGS don't last long enough to be effective.	.41
44. A SHG benefits its members.	.71
45. A SHG is an excellent resource for a helping professional.	.59
47. The professional helping community should support SHGS.	.72
49. Participation in a SHG is a move away from reliance on helping professionals.	.53
50. SHGS increase members psycho-social skills.	.59
52. SHGS encourage independence.	.58
53. Helping professionals should refer their clients to SHGS.	.65

Factor 2

Item #	Factor Loadings
6. Members of SHGS benefit most by being able to help someone else.	.35
22. SHGS offer a diversity of approaches which traditional therapies lack.	.51
25. Members of SHGS have natural helping expertise.	.51
26. The majority of people in SHGS have tried traditional therapies and rejected them.	.54
40. A SHG is preferable to traditional therapy.	.60
43. SHGS increase as professional services are rejected.	.44
48. SHGS are more appropriate than professional therapies for treatment of the stigmatized.	.42

Factor 3

Item #	Factor Loadings
21. The involvement of a helping professional with a SHG lessens the groups ability to help itself	.63
23. SHGS should be started by a helping professional.	.69
36. Most SHGS could benefit from a helping professionals expertise.	.71

Factor 4

Item #	Factor Loadings
1. SHGS are more similar to professional services than different from professional services.	.45
5. People who join SHGS also need traditional therapy.	.55
10. SHGS are a viable alternative to professional services.	.42
20. SHGS encourage members to conform to social norms.	.34
32. SHGS are not an alternative to traditional therapy.	.42
51. SHGS play a significant role in the prevention of mental illness.	.35

Of the 55 items for Section II, the panel of experts evaluated all but two items as appropriate for inclusion on the SAESHG. This evaluation indicated that the review of literature had been thorough, that the items had been well

chosen, and that they reflected the content of the field regarding self-help groups. The panel of experts' difficulty in agreeing on the content area of the items may have been due to the globalness of the construct area. Since no guidelines had been established in earlier studies as to the nature of the domain of attitudes toward self-help groups, it was decided that the constructs could best be identified through empirical methods.

According to Kerlinger (1973), content validation is basically judgemental. Content validity is based on the soundness of the method of construction of the items and the evaluation of the items by experts. From the thorough review of the literature and the panel's agreement as to the appropriateness of the items, the SAESHG was determined to have content validity.

In addition to the evaluation by the panel of experts, participants in the pilot study also were instructed to comment on the SAESHG in terms of format and content. Their comments that the SAESHG was easy to read and understand and their willingness to complete the SAESHG were taken as indicators of face validity. The participant response rate to Section II, 86.8% omitting 8 items or less, also was taken as an indicator of face validity. Although face validity is only one aspect of content validity, it is nonetheless desirable.

Construct Validity

Based on the literature review, several construct areas were hypothesized to be part of the domain of attitudes toward self-help groups. Because this study was a first attempt at identifying the constructs, rather global terms were used initially. The three hypothesized construct areas were purposes/activities, characteristics, and relationship to other helpers. Perhaps due to the globalness, the panel of experts had difficulty in agreeing in which construct area an item should be placed. Since the reason for the panel's difficulty was unclear, factor analyses were used to identify the construct areas.

From the factor analyses, one factor was identified for Section I, and four factors were identified for Section II. The loadings on the four factors in Section II placed the items in a similar pattern to their development. Items in factors 1 and 2 had primarily been placed in the content areas processes/activities and characteristics. Items in factors 3 and 4 had primarily been grouped together under the content area relationship to other helpers.

From a review of the items in Section II which loaded on factor 1, it appears that this factor is more general in scope. It also has the most combination of items from the other areas as developed and as chosen by the panel. It appears that factor 2 is composed of items which make a comparison and contrast between self-help groups and more

traditional therapy. This factor could be viewed as a more specialized division of the larger factor of relationship to other helpers. Items from factors 3 and 4 also appear to be part of this larger factor, relationship to other helpers. Since these factors are part of the three hypothesized construct areas and are internally reliable, this provided evidence regarding the construct validity of the SAESHG.

Internal Reliability

In order to estimate the reliability of the SAESHG factors, coefficient alpha, a measure of internal consistency, was computed for each factor. For Section II, the coefficient alpha for Factor 1 was .9062, for Factor 2 it was .6401, for Factor 3 it was .6567, and for Factor 4 it was .5581. These results indicated that the instrument had internal consistency. According to Nunnally (1978), coefficient alpha provides a good estimate of reliability in most situations, since the major source of measurement error is because of the sampling of content (p. 230). The extensive review of literature, a preliminary step in item development, was the foundation on which the SAESHG was built. This foundation provided the base for items which were found to be both valid and reliable.

CHAPTER 5

CONCLUSIONS, IMPLICATIONS, SUMMARY, AND RECOMMENDATIONS

Conclusions

Four conclusions were drawn based on the data presented in the study. One conclusion was that the SAESHG had content validity. A second was that the SAESHG had construct validity. The third conclusion was the SAESHG is reliable as demonstrated by internal consistency. The fourth conclusion was the SAESHG is a valid and reliable instrument for assessing helping professionals' attitudes towards self-help groups.

Implications

One implication of this study is that the SAESHG can assist in conducting research on self-help groups. The SAESHG provides a method of assessing helping professionals' current attitudes and their levels of experience. Should further refinement on the SAESHG provide evidence of its temporal stability, it will provide a method of assessing attitudinal change over time. By using the instrument to assess attitude change, a researcher can develop hypotheses

to explain present findings and to predict future direction based on current trends.

Another implication of this study is that the SAESHG can be used to make comparisons across populations. After validating the instrument on other populations, comparison studies can be made. By using the instrument with a variety of populations, profiles can be developed of those persons, groups, or regions most and least favorable toward self-help groups. These findings would generate new theories or confirm existing theories about the populations attitudes and experiences with self-help groups.

A third implication is that the SAESHG can be used as a quantitative measure to determine whether existing hypotheses concerning attitudes and experiences with self-help groups are substantiated.

A fourth implication is that the SAESHG can assist helping professionals in their consultation activities with other professionals or with self-help groups. An excellent method to begin the consultation process is through assessment of the consultees current attitudes and experiences. The SAESHG provides a means of assessing consultees attitudes and experiences.

The SAESHG also can be used by self-help groups as a means of evaluating potential consultants. By determining consultants' attitudes and experiences with self-help

groups, the self-help group can better decide whether they wish to retain consultants.

A sixth implication is that the SAESHG can be used by helping professionals to assess their clients. By giving the survey to clients, helping professionals can better determine whether or not to refer clients to self-help groups.

Another implication is that the SAESHG can be used as a preliminary assessment tool to aid in planning training activities pertaining to self-help groups. By assessing the attitudes of the trainees, trainers can prepare a program to challenge or strengthen these attitudes. Areas of experiential knowledge which are limited can be identified and appropriate opportunities created for the trainees.

By using the SAESHG to identify those professionals who have both experiential knowledge and positive attitudes toward self-help groups, these professionals can be enlisted in training activities. They can serve as important role models in training programs for collaborating with self-help groups (Borman, 1976).

A final implication is that the SAESHG can be used as a self-assessment tool by students in professional training programs. Using the SAESHG as a self-assessment, trainees can better understand their attitudes and experiences and identify areas in which they may want more training. Consultants can use the survey as a pre and post measure to

evaluate the impact of their training on trainees. A counselor education department can use the instrument with its trainees to better plan training or practicum experiences with self-help groups and/or to determine whether such steps are necessary.

Summary

An introduction, statement of the problem, need for the study, purpose of the study, significance of the study, definition of terms, and organization of the study was contained in Chapter One. A review of the related literature which included sections about the self-help movement, self-help groups and society, the power struggle between self-help groups and professionals, professional collaboration with self-help groups, self-help and research, and a summary was presented in Chapter Two. The research questions, theoretical basis, item development, pilot study, panel of experts item response, field test, and limitations of the study were described in Chapter Three.

The results of the study and a discussion of the results was presented in Chapter Four. Based on the method of construction of the items and the evaluation of the items by the panel of experts, the SAESHG was determined to have content validity. From the literature review, the factor analyses results, and the internal reliability of the instrument, the SAESHG was determined to have construct

validity. From the results of the coefficient alpha analyses, the SAESHG was determined to be reliable as demonstrated by internal consistency.

Recommendations

Further refinement of the SAESHG is strongly recommended. The following revisions to the instrument are suggested. First, additional demographic questions such as sex and race of respondent should be included in the first part of the SAESHG to collect further information on the population surveyed. Second, a not applicable or N/A response choice to Section I should be included. This would enable the respondent to indicate whether they had experience rather than the researcher assuming that the respondent had no experience because the item had no response. In Section I, some method to indicate the amount of experience should be included to distinguish between respondents who have years of experience versus those with minimal experience.

Third, several comparison studies should be conducted. In one study, all items which did not load at the 5.0 level should be deleted from the instrument. A comparison should be done with remaining items on factors 1 and 2 and with remaining items on factors 1, 2, 3, and 4. All items with means <2.0 or >4.0 also should be omitted in a comparison study. This would result in Factor 1 retaining 8 items,

Factor 2 retaining 4 items, Factor 3 with 4 items, and Factor 4 with 2 items. New items should then be created to allow more uniformity of factors. Factor 4 may need to be discarded altogether since most of the items are loading on Factor 2. Following instrument revision, it is further recommended that a test/retest be conducted with a small population to provide indications of stability.

Studies should be conducted using other populations for the purpose of further validating the SAESHG. These populations could include social workers, alcohol and drug abuse counselors, correctional counselors, members of self-help groups, and students in various helping professional graduate training programs.

Longitudinal studies should be conducted using the SAESHG with targeted populations to document attitudinal changes over time for the purpose of predicting future trends. Since the growth of self-help groups in the last 25 years, helping professionals have progressed from ignoring the phenomenon, to beginning collaboration, to perhaps enveloping the movement. Future studies are needed to assess the developing pattern.

APPENDIX A
PANEL OF EXPERTS

Dr. Thomasina Borkman, George Mason University, has had training in working with self-help groups in the areas of self-directed study, practical experience, and research. She has had experience with self-help groups in the following capacities: participant, interested observer, consultant, and researcher. Her publications include: Experiential knowledge: A new concept for the analysis of self-help groups in Social Service Review, 1976, 50: 445-456; Participation patterns and benefits of membership in a self-help organization of stutterers in A. Katz and E. Bender (Eds.), The strength in us: Self-help groups in the modern world , New York: New Viewpoints, 1976, 81-90; Experiential knowledge in self-help groups as the basis of selective utilization of professional knowledge and services, a paper presented at Pennsylvania Sociological Society, Pittsburg, October, 1977; Mutual self-help groups: A theory of experiential inquiry, Services Analysis Branch, NIAA (Xeroxed), 1979, among others.

Dr. Alan Gartner, Co-Director of the National Self-Help Clearinghouse at the City University of New York, has had training working with self-help groups through self-directed study, seminar/workshops, and practical experience. He has also been an interested observer, consultant, and researcher of self-help groups. His publications co-authored with Dr. Frank Reissman include, among others: Self-help in the human services, San Francisco: Jossey-Bass, 1977; Help: A working guide to self-help groups, New York: Franklin Watts, 1979; Professional involvement in self-help groups, Self-Help Reporter, 3, 4-5, 1979; The Self-Help Revolution, New York: Human Services Press, Inc., 1984.

Dr. Alfred Katz, University of California, has had training working with self-help groups through self-directed study, and practical experience. He has had experience with self-help groups as a participant, interested observer, consultant, researcher, and administrator of a national self-help group. His publications include: Self-help organizations and volunteer participation in social welfare in Social Work, 15, 52-53, 1970; Self-help groups in Western society: History and prospects, Journal of Applied Behavioral Science, 12, 265-281, 1976 and The Strength in

Us, New York: New Viewpoints, 1976 both co-authored with E. Bender, and Self-help and mutual aid: An emerging social movement?, American Review of Sociology,7, 129-155, 1981.

Dr. Bob Knight, has had training with self-help groups through self-directed study, practical experience, and as a research assistant in a self-help study at Indiana University. He has had experience with self-help groups as a participant, observer, consultant, researcher, and leader. His publications include: Self-help groups: The members' perspectives, American Journal of Community Psychology, 8, 53-65, 1980.

Dr. Thomas Powell, University of Michigan, has had training through self-directed study, seminar/workshop, and practical experience. His experience with self-ehlp groups has been as an observer, consultant and researcher. His publications include: The use of self-help groups as supportive refernce communities, American Journal of Orthopsychiatry, 45, 756-764, 1975; and Comparisons between self-help groups and professional services, Social Casework, 11, 561-565, 1979.

Dr. Richard Steinman, University of Maine, did not provide information on his experience and training with self-ehlp groups. His publication, co-authored with D. Traunstein was entitled Redefining deviance: The self-help challenge to the human services, Journal of Applied Behavioral Science, 12, 347-361, 1976.

Dr. Rubin Todres, University of Toronto, has experience as a researcher with self-help groups. His publications include Professional attitudes, awareness and use of self-help groups, Prevention in Human Services, 1, 91-98, 1982.

Dr. Ann Withorn, University of Massachusetts, has training with self-help groups through self-directed study and practical experience. Her experience has been as a participant, consultant, and leader. Her publications include Helping ourselves: The limits and potential of self-help, Social Policy, 11, 20-28, 1980.

APPENDIX B
Survey of Attitudes Toward and Experiences
With Self-Help Groups

1. What is your highest educational level?
   _____Bachelor _____Ph.D. or Ed.D
   _____Master _____Other_____
   _____Education Specialist (Ed.S.)

2. What is your present job title?_____
   (Check appropriate job category.)
   _____Counselor/Therapist _____Administrator
   _____Teacher _____Other_____

3. What training have you had in working with self-help groups? (Check as many as are applicable)
   _____College course(s) _____Practical Experience
   _____Self-directed study _____Other_____
   _____Seminar/Workshop _____None

4. In what capacity have you had experience with self-help groups? (Check as many as are applicable.) Next to the capacity, list the self-help group(s).
   ____Participant_____
   ____Interested observer_____
   ____Consultant_____
   ____Researcher_____
   ____Leader_____
   ____Other_____

Complete this section only if you have had some experience working with self-help groups.

Listed below are several means of collaboration between helping professionals and self-help groups. Please indicate all those areas in which you have worked with a self-help group by evaluating the effectiveness of those collaborations using the following scale:

1 - very ineffective
2 - somewhat ineffective
3 - neither ineffective nor effective
4 - somewhat effective
5 - very effective

1. Use self-help groups as a source of information 1 2 3 4 5
2. Publicize self-help groups active in the area 1 2 3 4 5
3. Make referrals to self-help groups 1 2 3 4 5
4. Share facilities with self-help groups 1 2 3 4 5
5. Receive referrals from self-help groups 1 2 3 4 5
6. Form an advocacy group or coalition with a self-help group 1 2 3 4 5
7. Integrate self-help group members into committees, board, etc. 1 2 3 4 5
8. Serve as a consultant to a self-help group 1 2 3 4 5
9. Use a self-help group as consultants 1 2 3 4 5
10. Provide training to a self-help group 1 2 3 4 5
11. Receive training from a self-help group 1 2 3 4 5
12. Conduct research on self-help group or phenomenon 1 2 3 4 5
13. Other methods of collaboration (please specify and rate effectiveness)

_____

_____

_____

_____

Listed below are several statements. Please respond to each by circling the appropriate number on the following scale:

1 - totally disagree
2 - somewhat disagree
3 - neither disagree or agree
4 - somewhat agree
5 - totally agree

1. Self-help groups are more similar to professional services than different from professionals services 1 2 3 4 5

2. The ideology of a self-help group alters when a professional becomes leader 1 2 3 4 5

3. Self-help groups are an important resource in meeting the mental health needs of society 1 2 3 4 5

4. Self-help groups foster support networks throughout the population 1 2 3 4 5

5. People who join self-help groups also need traditional therapy 1 2 3 4 5

6. Members of self-help groups benefit most by being able to help someone else 1 2 3 4 5

7. Self-help groups have positive effects on family relationships 1 2 3 4 5

8. Self-help groups are not a passing fad 1 2 3 4 5

9. Members of self-help groups benefit most from learning how others attempt to solve similar problems 1 2 3 4 5

10. Self-help groups are a viable alternative to professional services 1 2 3 4 5

11. Members of self-help groups don't want to be involved with helping professionals 1 2 3 4 5

12. Self-help groups are more harmful than beneficial 1 2 3 4 5

13. A self-help group is a powerful change agent 1 2 3 4 5

14. Self-help groups serve to educate the general public 1 2 3 4 5

15. Most people who join self-help groups are "on the fringe" of society 1 2 3 4 5

16. A professional can best collaborate with a self-help group by being a facilitator 1 2 3 4 5

17. Self-help groups empower their individual members 1 2 3 4 5

18. Self-help groups are not effective 1 2 3 4 5

19. Self-help groups do not reach those most in need of assistance 1 2 3 4 5

20. Self-help groups encourage members to conform to social norms 1 2 3 4 5

21. The involvement of a helping professional with a self-help group lessens the groups' ability to help itself 1 2 3 4 5

22. Self-help groups offer a diversity of approaches which traditional therapies lack 1 2 3 4 5

23. Self-help groups should be started by a helping professional 1 2 3 4 5

24. Sharing personal experiences is a major function of a self-help group 1 2 3 4 5

25. Members of self-help groups have natural helping expertise 1 2 3 4 5

26. The majority of people in self-help groups have tried traditional therapies and rejected them 1 2 3 4 5

27. Sharing information is a major function of a self-help group 1 2 3 4 5

28. People who use self-help groups for assistance are the same as those who use professional therapists 1 2 3 4 5

29. Anyone can benefit from a self-help group 1 2 3 4 5

30. Self-help groups "normalize" the needs of their members 1 2 3 4 5

31. Professionals have a great deal to learn from self-help groups 1 2 3 4 5

32. Self-help groups are not an alternative to traditional therapy 1 2 3 4 5

33. A self-help group substitutes reliance on a group for reliance on a helping professional 1 2 3 4 5

34. Self-help groups encourage members to give, not just to receive 1 2 3 4 5

35. A self-help group is more economically feasible than traditional therapy for most people 1 2 3 4 5

36. Most self-help groups could benefit from a helping professional's expertise 1 2 3 4 5

37. Helping professionals know as much as they need to know about self-help groups 1 2 3 4 5

38. Self-help groups increase members abilities to help themselves 1 2 3 4 5

39. Self-help groups should be regulated by the government for consumer protection 1 2 3 4 5

40. A self-help group is preferable to traditional therapy 1 2 3 4 5

41. Self-help groups are frequently involved in political activites or social advocacy 1 2 3 4 5

42. Most self-help groups don't last long enough to be effective 1 2 3 4 5

43. Self-help groups increase as professional services are rejected 1 2 3 4 5

44. A self-help group benefits its members 1 2 3 4 5

45. A self-help group is an excellent resource for a helping professional 1 2 3 4 5

46. Participation in a self-help group is a move away from reliance on helping professional 1 2 3 4 5

47. The professional helping community should support self-help groups 1 2 3 4 5

48. Self-help groups are more appropriate than professional therapies for treatment of the stigmatized 1 2 3 4 5

49. Participation in a self-help group decreases the stress of its members 1 2 3 4 5

50. Self-help groups increase members' psycho-social skills 1 2 3 4 5

51. Self-help groups play a significant role in the prevention of mental illness 1 2 3 4 5

52. Self-help groups encourage independence 1 2 3 4 5

53. Helping professionals should refer their clients to self-help groups 1 2 3 4 5

Please make any comments about self-help groups in the space below.

_____

_____

_____

Thank you for completing this survey. If you would like a copy of the results, please provide your name and address below.

_____

_____

_____

Return this survey to:

Lynn McRee
Borough of Manhattan Community College
199 Chambers Street, Room S773
New York, New York, 10007

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BIOGRAPHICAL SKETCH

R. Lynn McRee was born on July 2, 1950 in Montgomery, Alabama, the only child of Robert C. McRee and JoAnn Gottsberger. She spent her childhood in Alabama, Missouri, and Florida. Although she attended Auburn University for three years, she graduated from Florida State University in 1972 with a B.A. degree in psychology. She received her M.Ed. degree from Florida Agricultural and Mechanical University in Counselor Education in 1976. She combined her counseling and organizational skills to administer several federally funded grants until the birth of her second child. Currently she is a full-time mom to her daughters Jessa and Leah. She plans to resume grant writing on a part-time basis following the completion of her Ph.D. in August, 1989.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Roderick J. McDavis
Roderick J. McDavis, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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